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# **Constructions of clinical psychology in adult mental health: A discursive thematic analysis**

**DANIELA FERNANDEZ CATHERALL**

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## **Abstract**

In face of the current economic-political changes facing the UK and its State institutions and of the new evidence about the impact of social inequality on human distress, this study attempts to understand the increasing practice of delivering psychological therapy by the British clinical psychology profession.

A review of the critical histories of the profession in the UK identified the need for a more detailed study of the “history of the present” to reveal the discursive operations that construct professional practice. A discursive thematic analysis (DTA) based on the theoretical concepts of the late post-modern scholar Michel Foucault was used to explore public available documents produced by British clinical psychologists between 2010 and 2014.

Two dominant professional discursive themes were identified: alternative and leadership. These themes were found to be supported by the discursive sub-themes of applied science, well-being, Cognitivism and therapy which align the aspiration of the profession with those of the State. The tension between the applied scientist and the therapist role - specifically the need to establish simultaneously the profession’s scientific credibility and its therapeutic abilities in order to respond to market pressures – showed recurrences of the conflicts of the early history of professionalization of clinical psychology.

The positioning of clinical psychology against the use of functional psychiatric diagnosis and the challenges and opportunities identified by the opening of the NHS market to ‘any willing provider’ revealed how professional discourses operate to maintain the status quo. This study recommends that the socio-historical construction of the profession should be investigated further, in particular through the subjugated discourse identified here.

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## **Chapter One: INTRODUCTION**

The overall aim of this introductory chapter is to problematize the current professional practice of clinical psychology (CP) within the adult mental health sector in the UK to provide a rationale for this study. To achieve this, the chapter describes different sorts of evidence that influence the construction of current professional practices: the socio-political and economic context, the history of the profession, the institutional context, competing alternative practices and recent literature about the social inequality impact on the development of human distress.

To reflect the multiplicity of the socio-historical influences in constructing the profession of CP in the UK, the information in this chapter is divided in three distinct sections. Section 1 briefly contextualizes the current status of psychological knowledge and of applied CP practice to justify the relevance of this study.

Section 2, the largest section of this chapter, focuses on the process of professionalization of CP through the review of the existing historical studies of British CP and two large scale politically driven evaluations of the profession. The information in this section will serve two purposes: (1) justification of this particular study and (2) to serve as comparison to discuss the findings of the study (Chapter 3).

Section 3 provides more detail about the recent contextual influences that may have influenced the current professional practice of CP: these include changes within the NHS, recent developments within the profession's interventions, critiques of CP profession, emergence of alternative practices of psychology and evidence about how social inequalities impact on the development of psychological distress. The aim of this section is to finalize the problematization by presenting a series of challenges that the professional practice of CP currently faces. At the end of the chapter, a summary of the literature review will be combined with this problematization to formulate the research questions of this study.

## 1. CLINICAL PSYCHOLOGY: POWER AND PRIVILEGE

Since their emergence in the 19<sup>th</sup> century, psychological knowledge and tools, among other types of medico-scientific knowledge, have been increasingly applied to sustain a Westernised individualistic culture, which seems necessary for the success of these societies (Foucault, 1983; Hansen, McHoul, & Rapley, 2003). The valorisation of the individual and their psychological aspects has been extensively exposed and is well known within philosophy, social science and social psychology arenas. Foucault, in his later work, unified some of his analyses of the origin of madness, discipline and sexuality into what he called the 'culture of the self' (Dreyfus & Rabinow, 1983). He proposed that governmentality, the function of an organised State to provide leadership, guidance and organisation of the individuals within a society, is assisted by a series of institutional and professional practices which ultimately of act on behalf of the State on the internal regulation of individuals. Since the Enlightenment period, the attempt of using scientific knowledge in the regulating of bodies, which Foucault called bio-power, has been at the core of the conceptualisation and creation of the modern subject and the development of the modern State. The discipline of psychology and applied forms of psychology, such as clinical psychology, would also contribute to the creation of the modern subject and contribute to the internal regulation of the individual.

The powerful position of psychology in the current *zeitgeist* is visible in circles much wider than the consulting room. Recently, a number of developments in the UK, including the use of concepts drawn from positive psychology and social psychology theories by economists and politicians with a view to enhancing the performance of the State, the attempt to measure 'well-being' on a national scale and the creation of the Behavioural Insights Unit within the government (Cederstrom & Spicer, 2015), illustrate the wider influence of psychology. The 'Measuring National Well-being' programme launched by David Cameron in 2010 aimed to assess the outcome of specific government policies by measuring individual levels of happiness and well-being amongst the population (Cameron, 2010). This initiative has been endorsed and supported by the Division of Clinical Psychology (DCP) of the British Psychological Society (BPS), which has advised the Office of National Statistics (ONS) on the domains and measures to be used (Kinderman, 2011a).



## 1.1. Clinical psychology

Clinical psychologists are professionals who are competent to: (1) conduct psychological assessments, including specialised neuropsychological assessments through the use of psychometric tests; (2) develop psychological formulations of the difficulties presented by the people it attends to; (3) offer direct and indirect interventions to address the difficulties identified; (4) evaluate their intervention; and (5) to conduct research to further develop the theories, tools and techniques within the profession's repertoire (Beinart, Kennedy, & Llewelyn, 2008; Cheshire & Pilgrim, 2004; Committee on Training in Clinical Psychology, 2013; Hall & Llewelyn, 2006).

In the UK, CP is the largest form of applied psychology work corresponding to almost 48.2% of the number of registered applied psychologists as explained on Table 1 in section 3.1 below (BPS, 2010; Health & Care Professional Council, 2014). Clinical psychologists work with individuals, couples, families, groups, communities and services, covering the whole age span, all levels of ability and disability, a range of physical illnesses and mental health difficulties (Cheshire & Pilgrim, 2004; Cromby, Harper, & Reavey, 2013; Division of Clinical Psychology [DCP], 2010; Hall & Llewelyn, 2006; Llewelyn, Beinart & Kennedy, 2008). Clinical psychologists' training at doctorate level is funded by the NHS and they are employed in a variety of settings within health and social care services usually accessible through specialist teams across primary, secondary and tertiary care, GP surgeries, children centres, Community Mental Health Teams, general hospitals, specialist mental health services, etc, and these different settings are part of different institutions that have evolved historically (Cheshire & Pilgrim, 2004; Cromby et al., 2013; DCP, 2010; Hall & Llewelyn, 2006).

Clinical psychologists work in adult mental health, in primary care services, community mental health teams (CMHT), inpatient units and specialist teams such as Early interventions or Crisis teams. Clinical psychologists also work with children, young people and their families, in children and adolescent mental health (CAMH) teams, in inpatient units, supporting parents and infants in children services, in paediatric services in general hospitals, in pupil referral units, etc. Clinical

psychologists also work with older adults and people who have a diagnosis of a learning disability, in community teams and inpatient services. Clinical psychologists also work in the sexual health area, with those who have a neurological problem or have had an acquired head injury, in forensic services and with those who have a forensic history, in specialists physical health teams, to mention a few. Although all psychologists assess and formulate people's distress and plan an intervention to address them, the type of work that a clinical psychologist engages in each one of these services can vary substantially. For example, it is more common for a clinical psychologist to offer direct intervention through the provision of psychological therapy in adult mental health and it is more likely when working with people with a learning disability to offer indirect intervention through service consultation (Beinart et al., 2008; Cheshire & Pilgrim, 2004; Hall & Llewelyn, 2006).

Overall, the variety of CP interventions is large, ranging from the direct delivery of psychological therapies based on a variety of theoretical models, such as Behaviour, Cognitive, Psychodynamic, Humanistic and Systemic, to the indirect delivery of psychologically informed work. In terms of indirect work, clinical psychologists can offer interventions to service users through their work within teams and also via other professionals through consultation, supervision, training and teaching. Different specialities will have a different balance between these activities and their work may concentrate more in doing direct or indirect interventions (Beinart et al., 2008; Cheshire & Pilgrim, 2004; Committee on Training in Clinical Psychology, 2013; Hall & Llewelyn, 2006).

As a result of a socio-historical process of professionalization, described in detail in section 2, the majority of clinical psychologists concentrate on adult mental health (Beinart et al., 2008; Cheshire & Pilgrim, 2004; Cromby et al., 2013; Hall & Llewelyn, 2008; Hall, 2007a, 2007b; Kinderman, 2011c; Newnes, 2014). It is the practice within adult mental health services, in particular in primary and secondary care that is the object of the study of this thesis and additional current definitions of CP will be analysed and discussed in depth in chapter 3.

## 1.2. The turn to psychological therapy

To add to the justification for studying CP professional practice within adult mental health, it is important to discuss the increased recognition of clinical psychology in current British society in relation to other forms of psychological practice. Recently we have witnessed an increase in the popularity of highly specialised, disorder specific, evidence-based individual psychological therapies such as Cognitive Behavioural Therapy (CBT) (Hall, Lavender, & Llewelyn, 2002; Layard, 2005). Despite critiques revealing the limitations and dangers of traditional psychological therapies, (e.g. Masson, 1994; Smail 2001), CBT has become a dominant form of clinical psychologists' intervention in this country, to the point that professionals market themselves as CBT experts (Hall & Llewelyn, 2006; House & Loewenthal, 2008).

Indeed, the unprecedented investment of £173 million from the Department of Health (DH) in the Improving Access to Psychological Therapies (IAPT) programme in 2006 has for some professionals been a major contributor to the dominance of the therapy discourse within the profession (Hassal & Clements, 2011). IAPT is based on a socio-economic argument that CBT interventions could help the large number of citizens suffering with mild to moderate anxiety and depression to return to work (Layard, 2005). This argument was criticized by Pilgrim (2007) who found Layard's economic argument to be theoretically sound but its psychological and social claims naively narrow and misleading. Despite a multitude of critiques from professionals within mental health services and a variety of other providers of psychological intervention, IAPT was implemented across the UK to address social and unemployment problems. And CP was put into its leadership.

This is an interesting historical time to observe how the profession of CP responds to top-down demands that influence its practices. A series of recent structural changes to the National Health Service (NHS), the institution that has been the place of the birth and development of the profession in the UK, may have an impact on the future of the profession. Changes to the curriculum of training programmes in CP, determined that trainees had to be skilled in delivering CBT alongside at least one other therapeutic modality at the end of the training (Committee on Training in

Clinical Psychology, 2013) and CP as a specialist in CBT and now it is officially stated by the Health and Care Professionals Council (HCPC) regulation 2.b.4. that clinical psychologists ought to be skilled in the delivery of CBT (Health & Care Professional Council, 2014, p.22).

This narrowing of the professional practice of CP into becoming an expert in delivering CBT has great impact on the other areas in which clinical psychologists work (Hassal & Clements, 2011). Therefore, it is essential that the profession of CP should be investigated. I will review further the recent changes within the NHS and within the guidelines for training in CP in section 3.1. To better understand the process of socio-historical construction of CP, the following section will review the literature on the subject.

## **2. INVESTIGATING THE PROFESSION OF CLINICAL PSYCHOLOGY IN BRITAIN**

To continue building the argument for this study, this section concentrates on the professionalization of CP. It will first define professions, the professionalization process and outline the current best practice in formally analyzing professions. It will secondly describe how this literature review was conducted and summarise the key findings of the most relevant research. The studies reviewed were separated into two sub-sections to correspond to their different research designs. Section 2.3 summarises historical analyses and section 2.4 summarises two large scale evaluations of the profession commissioned by government departments and the BPS.

The information contained in the literature review below has two functions in this study: (1) it is used in this chapter to identify recommendations and gaps within the literature to justify conducting this particular study and a summary will be included in section 3.4, at the end of this chapter; and (2) this information will be considered as the 'past' of the professional history of CP and it will be used to compare and discuss themes encountered in the study of the 'present' of the professional discourses in chapter 3, analysis and discussion.

## 2.1. Studying professions

Rogers and Pilgrim (2010) explain that when sociologists began the study of professions, they would ask professionals to talk about themselves, which resulted in uncritical and superficially naive views of the profession, similar to the one usually held by the lay public. The results of these first studies were that by 'professional' one would mean someone who uses a distinct set of skills competently, efficiently, ethically and in an altruistic manner to attend the public need.

Taking an outsider approach and exploring the history and the context of a profession, makes it possible to identify a different position, revealing a less altruistic and more self-serving construction (Rogers & Pilgrim, 2010). A classic example of this is Ivan Illich's (1995) exposure of the less benign side of the medical profession. His scholarly work revealed how medical knowledge became a monopoly of this elite profession and supported the transformation of health services into a private and lucrative business in most parts of the world. This work resulted in him coining the term 'iatrogenic effect' referring to problems created by the medical doctor in their interaction with a patient.

Currently, critical studies rely less on professionals' accounts and more on the context, facts, statistics, history and professionals' discourses for their understanding (Rogers & Pilgrim, 2010). Some of these critical studies have drawn from the range of theories that have conceptualised professions, from the benevolent early vision of Durkheim, passing through Weber's understanding of bureaucracy and Marx's analysis of class. More recently, post-structuralist ideas of power and discourse, such as Foucault's, have gained prominence within the field (Cheshire & Pilgrim, 2004). According to Rogers and Pilgrim (2010), despite all these different analytical frameworks, professions could be characterised in these ways:

1. Professionals have grown in importance over the past 200 years and expanded massively in number during the past century;

2. Professionals are concerned with providing services to people rather than producing inanimate goods;
3. Whether salaried or self-employed, professionals have a higher social status than manual workers;
4. This status tends to increase as a function of length of training required to practice;
5. Generally, professionals claim a specialist knowledge about the service they provide and expect to define and control that knowledge;
6. Credentials give professionals a particular credibility in the eyes of the public and government alike. (p. 133)

CP is a profession that fulfils all the criteria above and has been through a process of professionalization in the UK over the past 60 years, with continuous changes and developments that will be described below.

## **2.2. Studying clinical psychology and the literature review**

Recent studies of CP as a professional practice have been historical analyses and, following the same trends observed within sociology, they have made use of post-structuralist and eclectic frameworks (Rogers & Pilgrim, 2010). Bunn (2001) has argued that currently the most acceptable way to study the history of psychology is using post-modern and contextual approaches that are able to account for the reflexivity of the discipline that constantly creates itself by defining and re-defining its object.

In order to identify these historical studies of CP this literature review has followed four steps. Firstly, I located primary relevant publications in reading lists from lectures and identified standard texts about the profession of clinical psychology. Secondly, I searched the reference lists of these primary publications for further specific literature. Thirdly, discussions in supervision and with other senior clinical psychologists indicated further titles. Fourthly, formalised and systematic literature

researches were conducted using specific and generic electronic search engines, such as EBSCO, Ovid and Cambridge Journals, Google and Google Scholar.

The systematic literature searches were conducted in two waves to account for new publications. The first wave took place between July 2010 and November 2011. A second wave of searches was conducted in November 2013. The following words and terms were used in different combination within the search fields of 'title', 'sub-title', 'abstract' and 'subject': 'clinical psychology', 'British clinical psychology', 'psychology', 'professional psychology', 'professional clinical psychology', 'genealogy', 'Foucauldian genealogy', 'history', 'history of the present', 'historical analysis', 'critical historical analysis', 'study of mental health professions', 'study of mental health professionals', 'historical analysis of clinical psychology profession', 'historical analysis of clinical psychology profession in Britain', 'genealogy of clinical psychology' and 'clinical psychology: a genealogy'. The literature search kept the 'date' fields blank to include as many results as possible.

The abstracts of papers identified in the searches were then reviewed for relevance. The following exclusion criteria were adopted during the preliminary reading of abstracts: (1) studies about the history of CP in other countries were disregarded, (2) as were studies which used an interpretative methodology and did not focus on history, e.g. a study that used psychoanalytical theories to understand the developmental stage of clinical psychology was excluded.

After this process, more than 30 titles of varying sizes and *foci*, from books, book chapters, journal articles, periodical articles to reports were then scrutinised in more detail. The principles adopted to evaluate and select the literature reviewed in the following section were:

(1) The object of the study was British CP, as we understand it today, although some relevant work that focused on the common pre-history of the different applied psychological practices, before those were split into different specialties, were also identified as relevant and used here, such as Hearnshaw (1964) and Rose (1985).

(2) They considered within their analyses the multiple systems that influence CP professional practice, i.e. they have included the institutions in which applied psychologists worked and the wider influence of State policies.

(3) They presented an internal methodological consistency throughout the analysis.

(4) They discussed the practice of clinical psychologists providing psychological therapy to adults at some point within their analyses.

As mentioned at the beginning of this chapter, the function of this literature review is firstly, to demonstrate the need to continue the research, especially in light of the recent increased focus on the provision of psychological therapy in adult mental health mentioned in section 1.2., above. And, secondly, some of the key findings described below will be used in Chapter Three to compare the findings of this study against.

### **2.3. Historical researches findings**

It is also worth noting at the beginning of this section the most common methodological limitations encountered amongst the studies presented here. The majority of them were conducted by clinical psychologists themselves such as Cheshire and Pilgrim (2004), Hall, Lavender and Llewelyn (2002), Hall (2007a, 2007b), Newnes (2014) and Pilgrim and Treacher (1992), which is in itself a limitation of the studies of professions as indicated in section 2.1 above. Some studies were also limited to a simple description of events and focused on the work of key individuals, e.g. Miller (1996). Other studies provided personal accounts of authors, such as McPherson and Sutton (1981) and Newnes (2014), which, while taking a critical stance and considering the socio-political-economic-cultural and historical context, still reflect personal views.

There are also traditional historical accounts that attempted to follow an orderly and longitudinal approach to describe the development of psychology, such as Hall et al. (2002) and Hearnshaw (1964). Analysing history in a chronological and longitudinal



way has been criticised for failing to reveal wider contextual influences within CP, and for promoting a limited view of psychology that serves inadvertently to perpetuate the profession's naive claim of scientific neutrality (Bunn, 2001; Harris, 2009).

### 2.3.1. Clinical psychology growth resulted from changes within psychiatry

Hearnshaw (1964) wrote the first longitudinal historical account of the discipline and practice of psychology, which included CP and aimed to show the development of the interest of a few individuals studying philosophy in the 19<sup>th</sup> Century led to a science, practice and profession.

Making use of documentary material and individual accounts of key figures in the profession Hearnshaw's (1964) analysis was limited to outlining 'broad trends' of practices, academic work, personal interests and histories of key individuals, interest groups and organisations. Hearnshaw stated that the study of the history of psychology dates from the development of the discipline itself, as from the beginning it has been a great concern to understand its philosophic-scientific epistemological basis in a world itself in transition. His work identified the influences within psychological theory and practice of intellectual tendencies and wider socio-economic and political contexts such as Social Darwinism, Eugenics, Socialism, Materialism, Idealism, Psychoanalysis and Behaviourism (Hearnshaw, 1964). He also affirmed the distinction of British CP in relation to the profession in the US because of the specific socio-cultural background of Britain.

Hearnshaw (1964) concluded that early applied psychology practice gained its independent status through practical application after the Second World War within the emerging mental health field and not as a consequence of its academic-theoretical developments. Hearnshaw argued that although some activity of assessment conducted by applied psychologists dates from the end of the 19<sup>th</sup> century, this increased considerably in the 1930s with the emergence of CP *per se* and other professions subordinated to psychiatry, such as psychiatric social workers and occupational therapists. At the time psychiatrists in the UK had grown to

question psychoanalysis and had started to attribute the causes of mental illness to genetics, stress, pharmacological and biochemical factors, as well as starting to use treatments such as convulsion therapy, insulin therapy and leucotomy that made it possible for other competing forms of intervention to be adopted. Opening up to other forms of treatment would also open up the field for psychological assessment and intervention.

### 2.3.2. Clinical psychology profession more influenced by its practical application than its theories

Rose (1985) conducted a genealogy, based on the concepts of Michel Foucault, to look for the conditions of emergence of the 'psychology of the individual' as a scientific discourse and a body of social practices. Using documentary material alone, and covering a similar historical period as Hearnshaw (1964), he demonstrated how applied psychology was used in institutions to assess society's 'abnormal' minority of the time: 'The feeble-minded individual, the shell-shocked soldier, the inefficient worker, the maladjusted child, the juvenile delinquent (...)' (Rose, 1985, p. 6). Rose did not tackle the question of the intervention or therapy role of CP, instead his work focused on the conditions of possibilities for the establishment of psychology as a recognised form of knowledge in the areas now defined as educational, clinical and organisational psychology.

Rose, similarly to Hearnshaw (1964), concluded that it was the applied nature of the practice, supported by the developing statistical science, the disease model used by medicine and the ideas of population control and surveillance dominant during the 19<sup>th</sup> century, which created the conditions to legitimise a psychological knowledge focused on the individual. 'The issue of adaptation – of establishing the laws and charting the variations of the relations between individual conducts and social expectations – was central to the project of individual psychology.' (p. 225). Rose's analysis revealed that psychology was established by combining (1) an attempt to mirror the scientific relationship that medicine had established between the pathologies of the body and numeric representations, with (2) a hurried need to

develop the application of intelligence tests to fit within the wider contextual needs of the time (Rose, 1985).

Rose also argued that this psychological knowledge, applied within state institutions, produced a 'moral control' function that served the wider societal needs of the time and resulted in the empowerment of the discipline. In contrast to the trajectory of medicine, that was eventually able to match statistical analyses with observable pathologies within the body to reliably diagnose and treat physical ailments, the psychology of the individual ended up becoming an administrative rather than a clinical practice as it developed techniques without theories.

### 2.3.3. Institutional medicalisation of clinical psychology and the scientist-practitioner identity

Pilgrim and Treacher (1992) conducted a socio-historical and cultural review of CP *per se*, aiming to examine the profession's history to critique some of its practices. They wanted to understand how in the 1990s CP emerged as powerful, professionalised and self-promoting despite its confused search for identity and the impact of the convoluted politico-economic and cultural context of the 1970s and 1980s. Making use of documents and interviews with key players in the profession the authors concluded: '(...) that it was precisely the fleshing out of the clinical psychologist's role as an active practitioner, able and willing to engage in therapy, that in fact contributed to the rapid development of the profession.' (Pilgrim & Treacher, 1992, p. 72).

Pilgrim and Treacher (1992) also concluded that professional practice was greatly influenced by its beginning as an accessory and subordinated profession to psychiatry and that this medical dominance was unavoidable because CP began its existence in a terrain already dominated by psychiatry, which determined from the start the medicalisation of the mental health system in Britain.

Pilgrim and Treacher (1992) observed that the scientist-practitioner identity served the profession well since its origins within the 'laboratory', focused exclusively on the

development and application of assessments to support psychiatric treatment, evidenced by the argument of Hans Eysenck (1949). The achievement of this unified identity in Britain was not easy because of the conflicts between the different theoretical bases underpinning the practice in the few centres of development of CP in the early days: the Institute of Psychiatry (IOP), the Tavistock Clinic, University College London (UCL), the Royal Dumfries Hospital in Scotland, and the Psychology Laboratory in Cambridge. The role of psychological therapy was a conflicted one, because of the identification that psychological therapy had at the time with psychoanalysis and the strong British legacy of Freudian and Object Relations theories that would not match the positivist and scientific identity aspired to by CP.

Pilgrim and Treacher, like other authors such as Miller (1996) and Hall et al. (2002), stated that in the US the Boulder model had provided the rationale for the inclusion of the therapist role within the scientist-practitioner model much earlier than in Britain. The Boulder model, named after the city in Colorado that hosted a conference of the American Psychological Association (APA) where the professional role of clinical psychologists in the US was discussed, is often used as a synonym for scientist-practitioner model of clinical psychology practice. By scientist-practitioner is understood the application of scientific principles and theories into the clinical practice of psychology which goes beyond the direct provision of psychological therapy.

During the Boulder conference discussions influenced by the lobby of the US Veterans Association and existing applied psychology practices that provided psychological therapies, advocated the inclusion of the provision of therapies within the role of CP in the US (Cheshire & Pilgrim, 2004; Newnes, 2014; Hall, 2007a, Hall et al., 2002; Pilgrim & Treacher, 1992). Although originally proposed as a model of training in CP (Hall, 2007a), later the Boulder model became used as a model of professional practice.

According to Pilgrim and Treacher (1992), British CP initially opposed the Boulder model and would only come to accept the inclusion of therapeutic interventions within their professional role with the development of Behaviour therapy in the 1950s and 1960s. Behaviourism and Experimental Psychology theory and principles were

deemed to be empirically driven and provided the means to test hypotheses that would eventually fit well with Monte Shapiro's ideas of the 'single-case approach' proposed within the IOP (Pilgrim & Treacher, 1992).

Pilgrim and Treacher (1992) attributed the development of British CP to the addition of the therapist role within CP. However, the authors evaluated and contrasted research evidence to conclude that the scientist-practitioner rhetoric is mostly used to defend CP's professional position among other professionals within MDTs, as in fact little research is actually produced or consumed by clinicians in their daily practice.

The authors cited Norcross, Brust and Dryden's (1992a; 1992b) results of the first national survey of the Clinical Division of the BPS, which would in time become the present day DCP. Of a sample of 993 full and active members of the division (corresponding to 46.9% of the total membership at the time), ninety four percent of the British sample reported to providing therapy, taking on average 36% of their working time, and seventy one percent reported routine involvement in research activities, this taking, on average, 14% of their working time (Norcross et al., 1992a). Ninety nine percent of the clinical psychologists that reported providing psychological therapy said that this would be individual therapy, and accounted on average, for 74% of their working time.

Norcross et al. (1992b) presented more details about the research and academic activities of the same British sample described above. Seventy one percent primarily viewed themselves as a clinical practitioner, while only 5% viewed themselves as an academic and 4% as a researcher. In terms of the research productivity of the sample, measured by number of articles published, authorship or edition of books and conference presentations, the modal number was zero for all of four types of publication. Although this result meant that the vast majority of the sample of full and active members of the Clinical Division of the BPS had at least once in their careers publicised their research amongst their peers, it also meant that 24% of the sample had never published an article and 36% had never presented a paper at a conference. Although 21% of the sample had been involved in writing and edition of

books it was actually identified that almost half of all publications were produced by 8% of the total sample.

More recent studies, using similar methodology (samples and questionnaires), have replicated the finding that the modal number of research publications among clinical psychologists in the US is zero (Brems, Johnson, & Gallucci, 1996; Norcross, Karpiak, & Santoro, 2005). In Britain, the most recent survey of a representative sample of 374 members of the BPS DCP published by Eke, Holttum and Hayward (2012) has also replicated this result. In summary, the authors found that the median number of publications by British clinical psychologists, at any one time, was 3.6 and the mode was zero. Sixty percent of the sample had at least one empirical publication, 45% had at least a non empirical application, 25% had published at least one book or chapter and 60% had presented their research at a conference. Interestingly, 51% of the sample reported the intention of conducting research over the following year.

The current evidence continues to indicate Pilgrim and Treacher's (1992) argument that the scientist-practitioner model is a rhetoric used by clinical psychologists to justify their enhanced status when compared to other providers of psychological intervention. Their survey of the course descriptions of 1989 and 1990 revealed that the rhetoric of the scientist-practitioner model was widely used, even Shapiro's complex and case focused version (Pilgrim & Treacher, 1992).

Pilgrim and Treacher also concluded that clinical psychologists had become worried about the competition within the market for therapeutic interventions as their psychological knowledge claims had somewhat weakened after the turn to behaviourism in the 1960s and eclecticism in the 1970s due to the growth in interest in humanism (Pilgrim & Treacher, 1992). The pressure to regulate the profession had become an imperative but the discussions about the limitations of the scientist-practitioner role were suspended when the profession had, once more, to defend its existence and position within the NHS in the 1980s (Pilgrim & Treacher, 1992). The authors' final conclusions were that, as a profession, CP seeks to protect its market niche using strategies such as cornering the market and mystifying their practice.

Pilgrim and Treacher clarified that ‘mystifying’ one’s profession, as CP did in the 1980s, was a strategy to resist ‘de-skilling’, a concept invented by Oppenheimer that explains the pressure felt by white-collar workers, such as applied scientists within an organisation such as the NHS, who are at risk of being replaced by lower cost colleagues who could learn to deliver their specific set of routine skills if these could be easily understood and translated into task-like actions. Alongside this strategy, Pilgrim and Treacher pointed to the idea of ‘clinical judgement’ and ‘clinical experience’ as rhetoric resources used by CP to justify the need for their profession and to challenge bureaucratisation and managerialism within the NHS.

#### 2.3.4. Interests of the BPS and its influence on the shaping of clinical psychology

For Lovie (2001), exploring the origins of the BPS, it was the re-structuring and expansionist drive under C.S. Myers’s leadership that would lead to the empowerment of the organisation and contribute to the professional development of CP. Initially membership criteria were very selective, only allowing those with publications and peer recognition of teaching in psychology to call themselves psychologists: a very difficult standard to achieve as the discipline was only just beginning. These positivist aspirations were the reason for the slow and elitist growth of psychology (Lovie, 2001, p. 98).

In 1918, after hearing Myers’ threat that the Society would be sidelined by ‘outside’ practitioners of psychology, referring to those in the medical, educational and industrial fields, who were considering organising other societies for themselves, the Society made small changes that would finally open the ‘(...) doors to the hordes of the unwashed(...)’ (Lovie, 2001, p. 101). The wording of the membership criteria changed from ‘engaged’ to ‘interested’ in psychology and specialist sections were created resulting in the increase from 98 members in 1918 to an extraordinary 631 members by the end of 1920. Lovie (2001) put this down to the great number of military medics and physicians known to Myers through his work with shell-shocked soldiers from the First World War, as the numbers plateau later on. This is an important fact in terms of understanding the process of professionalization of

psychology as it was in fact this move out of exclusivity that brought the growth of the profession (Lovie, 2001).

In addition, Lovie (2001) highlighted as significant the efforts made by the BPS in the 1930s towards the idea of creating a public register of psychologists to assure the public of their qualifications and credentials, which would only be achieved in the 1990s. Later on this would be followed by the BPS investment in becoming a professional body and obtaining Chartered status for individual psychologists which would give officially the power claimed by the profession. Throughout this process, membership criteria was revised and eventually tightened up to exclude those without a degree in psychology almost returning to the original model, although not as narrow (Lovie, 2001).

Thomson (2001) investigated the BPS promulgation of a scientific psychology. He analysed how the BPS psychology, responded to the 'Practical Psychology' movement of the 1920s and 30s. The 'Practical Psychology' movement was formed by religious and lay practitioners of psychology under organisations such as the British Union of Practical Psychologists and the British Federation of Psychologists. The popular psychologists offered guidance and support through the use of self-help manuals to a public that demanded explanations for their everyday difficulties, which neither the medics nor the BPS psychologists were providing. BPS psychology at the time was concentrated in academia and lacked contact with the public and this informal movement had grown and was becoming well established in Britain in parallel to the BPS developments. Thomson (2001) concluded that the need to gain this 'market' within the public that would drive CP to establish itself as the officially recognised practice of psychology. According to Thomson (2001) it was the BPS reaction to this movement that created the conditions for the popularisation of scientific psychology in Britain and not necessarily the therapeutic interventions being developed by the academic psychologists that would serve to strengthen the professional niche.



### 2.3.5. The therapy market and its demands

Hall, Lavender and Llewelyn (2002) conducted a comprehensive study of the history of CP in Britain from its roots before the Second World War to the year 2002. After observing the growth and influence that British CP had in its 50 years of formal existence the authors questioned the development of the profession, in terms of its dominance in the applied psychology field, its relationship with academic psychology, its relationship with the NHS and broader social changes. Like Pilgrim and Treacher (1992), they were curious about the ways in which the profession managed its internal and external obstacles. Using documentary material their analysis explored 'within a conceptual, political and professional matrix' (Hall et al. 2002, p. 32) the main roles played by key professionals.

Among several conclusions, Hall et al. (2002) argued that the turn to therapy was down to two factors: (1) making training and employment in the NHS more attractive to psychology graduates and (2) the personal preference of clinicians in the NHS facing the public demand for therapy. They discarded the Eysenckian rhetoric and the influence of the American Boulder model that some other authors had identified. Pilgrim and Treacher (1992) also concluded that the shift to therapy was most likely caused by an NHS that was desperately in need of therapists and not scientists.

Hall et al. (2002), in agreement with Pilgrim and Treacher (1992), took the view that therapy as part of the CP role was a result of the continued separation of psychoanalysis from the mainstream academic psychology in Britain and not from the American influence: 'The tension between, at the extreme, radical behaviourists and die-hard Freudians, however, has continued to ripple through British training and practice, despite the more recent espousal of a broadening range of therapeutic models.' (Hall et al., 2002, p. 36)

Another factor related to the growth of the profession was the expansion of the University system in Britain in the 1960s; until then the number of graduate psychologists and lecturers in the field were minimum. 'In turn, interest in abnormal psychology as a special option, which was itself dependent on good undergraduate teaching in these areas, began to grow, albeit slowly.' (Hall et al., 2002, p. 38)

Hall et al. (2002) provided a good summary of the changes that British CP had experienced in the previous 30 years amplifying the range of theories and foci: the uptake of CBT, acceptance of systemic and Cognitive Analytic Therapy (CAT) approaches, a shift from diagnosis to problem-orientated case formulation, an increased acceptance of qualitative research, broader concerns as quality of care, user and carers' perspectives, a rich interplay resulting in a close relationship between researchers, trainers and leading clinicians.

Hall et al. (2002), similarly to Pilgrim and Treacher (1992), also raised the issue of the other therapists: counsellors, psychotherapists and other psychology practitioners. A lot of development has happened within these practices alongside CP over the last 50 years although: 'What is significant about all of these developments is that the NHS has not formally recognised these other professional groups, nor committed itself to funding their basic training.' (p.43)

#### 2.3.6. Clinical psychology's ambiguity and segmentation unavoidable within NHS

Cheshire and Pilgrim (2004) provided a critical historical review of CP using a sociological post-modern framework to evaluate documents in order to unravel how CP's context within the NHS had been responsible for both the uniqueness of the profession and the similarities with the other psy-professions.

Cheshire and Pilgrim (2004) recapitulated the conclusions arrived at by Pilgrim and Treacher (1992) and the influence of CP's positivist and empiricist roots within simultaneous developments within the NHS. They argued that CP is a 'syncretic profession', because of its dual role in academia and in the clinic, represented by its the scientist-practitioner identity, which leads to a split and conflicted knowledge base derived simultaneously from both science and social values. The syncretism of the scientist-practitioner identity makes the profession as a whole suffer from on-going pressures from within: '(...) much of the internal conflict within the profession stems from disagreements between members about the validity and appropriateness

of its scientific and normative roles' (Cheshire & Pilgrim, A short introduction to Clinical Psychology, 2004, p. 30).

In addition to Pilgrim and Treacher's (1992) conclusions in relation to professional closure, boundary protection and the ethnicity and gender imbalance of the profession, Cheshire and Pilgrim (2004) have continued the analysis of these strategies and concluded that CP training and clinical practice focused on the search for further legitimacy in the 1990s. This transformed the post-graduate training from a master's degree into the doctorate form of the present day, which approximates the qualification of clinical psychologist to that of medical doctors. The authors also found it to be significant that clinical psychologists in higher hierarchical positions adopted the title of 'consultant'.

Cheshire and Pilgrim (2004) concluded that the role and political ambiguity of CP and its segmented practice was unavoidable as the practice of the profession has to take place in many different institutional settings, the NHS and other State institutions. Clinicians have agreed mostly with how they deliver their work in terms of assessment, formulation, intervention and evaluation but have not agreed with the theories underpinning these: 'Some clinical psychologists are committed to a conservative pro-medical and positivist naive realist view of the world. This may extend to forms of biological reductionism and genetic determinism. At the other extreme are psychologists who are radical environmentalists or radical constructivists and who seek illumination in their work by studying social and economic relationships.' (Cheshire & Pilgrim, A short introduction to Clinical Psychology, 2004, p. 135). According to Cheshire and Pilgrim (2004), these differences are not necessarily detrimental to CP, it helps the profession to survive and gives clinicians some flexibility to attend to localised needs.

#### 2.3.7. British clinical psychology and an unusual professionalization process

John Hall (2007a), analysing the literature of the history of CP in Britain identified a confounded rhetoric explaining the formation of the core tasks of the profession, including some of the studies reviewed above. He questioned the literature's

repeated use of similar stories about the emergence of the profession of CP in the UK: its subordination to Psychiatry in adult mental health, the influence of the American Boulder model and the leadership of Hans Eysenck (Hall, 2007a). To verify the actual influence of these stories in the formation of the British CP between 1943 and 1958 Hall (2007a, 2007b) conducted a documentary analysis, based on sociological and Foucauldian understanding of professionalization.

Hall (2007a, 2007b) identified the plurality of practices and theoretical bases in use by the different early applied psychologists and the organised groups that represented them, such as early 'divisions' within the BPS, practicing psychoanalysts, medical doctors and even the popular psychology organisations discussed by Thomson (2001), described above in section 2.3.4. He concluded that consolidation of the expected tasks of applied psychologists in the UK was only achieved pragmatically because of the Second World War and the formation of the NHS (Hall, 2007a).

With the outbreak of the war, the Ministry of Health supported and funded the formation of the National Council for Mental Health in 1939, which amalgamated the existing Central Association for Mental Welfare, the Child Guidance Council and the National Council for Mental Hygiene. This new organisation directly connected the practice of psychologists of the Child Guidance Clinics with the ideas of the International Mental Hygiene Movement, which advocated mental health promotion and focus on early intervention through preventative work with children and families.

Hall (2007a) identified peculiarities in the process of professionalization of CP in Britain in the light of the negotiations of the Committee of Professional Psychologists (Mental Health) (CPP MH) of the BPS with the new, disorganised and underfunded NHS. According to Hall (2007a), the profession was 'created out of virtually nothing within one monopoly employer' (Hall, 2007a, p.38). The CPP MH was a very small interest group, separate from the Medical Section and subordinated to the BPS Council, that first met in 1943 and in the following 15 years would be directly involved in the negotiation process that defined professional and training standards that psychologists would have in the health settings within the new NHS (Hall, 2007a). It was through the CPP MH negotiations via the Whitley Council System that ensured

the inclusion of clinical psychologists within the 'Professional & Technical A' (PTA) staff grouping, which ensured the scientific role of the non-medical graduates.

Analysing the minutes of the CPP MH, Hall (2007a) identified that the work of this committee was in fact conducted by the members of the Child Guidance Clinics, mostly female educational psychologists, lay child psychotherapists and play therapists from the Tavistock Clinic (Hall, 2007a). The educational psychologists were originally teachers who developed their psychological practice working with children having difficulties within the school environment, conducting assessments and use psychometric tools in their daily practice (Hall, 2007b). There were also a minority of psychologists working with people with learning disabilities, similarly using the same practice of psychometric based assessments to establish a program of vocational rehabilitation (Hall, 2007a and 2007b).

Hall (2007a, 2007b) argued that the models of working with children and families of the members of the Child Guidance Clinics, which were psychodynamically orientated and made extensive use of psychometric assessment tools, were the ones that were actually transferred to adult care with its formation in the NHS (Hall, 2007a, 2007b). In fact, Hall (2007a) did not find any evidence of psychologists working with adults within the committee's minutes until 1945.

The first mention of 'clinical psychologists' within the minutes of the CPP (MH) happened in 1947 with regards the discussion of standards and conditions of employment of these professionals and educational psychologists within the NHS (Hall, 2007a). In 1948, it was decided that psychologists should be included in the Whitley Council system with a representation from the CPP MH through the Association of Scientific Workers (AScW), a trade union. In that same year the BPS decided that psychologists should have a degree in psychology and discussion of the inclusion of clinical psychologists working with adults within the CPP MH began. Hall (2007b) concluded that it was the restriction of the BPS membership to those who had a degree in psychology and the increasing supply of those graduates over the years that were essential to the professionalization of CP in the UK.

With regards to the work within adult mental health, up to the 1950s Hall (2007a, 2007b) only found evidence of psychologists working with adults with learning disabilities and acquired head injury in health settings. For many years to follow psychologists practicing with adults would be outnumbered by those practicing with children (2007a; 2007b). The work of psychologists with adults started in the 1950s in the asylums and hospitals for people with learning disabilities which was a much larger and complex environment than the schools or teaching hospitals where the first applied psychologists of the CPP MH had worked (Hall, 2007b). Hall (2007b) acknowledged that little is known by the varied and isolated practices away from London that few individual applied psychologists may have had within the large asylums at that time.

In 1950 the creation of the sub-committee on adult clinical psychology was formed, including membership of Monte Shapiro, from the Maudsley Hospital's clinical and teaching section of the first post-graduate training course in the UK, and of Hebert Philipson, from the Tavistock Clinic. Hall (2007a) found that although Hans Eysenck was named as a deputy for Monte Shapiro within the CPP MH, he resigned in 1953 without ever actually participating in any meeting. This evidence challenges the influence that other authors attribute to Hans Eysenck on the development of CP in Britain, such as Cheshire and Pilgrim (2004) and Pilgrim and Treacher (1992). Hall (2007b) demonstrated how alongside other key male psychologists who took leadership positions after their direct or indirect contribution towards the war efforts, such as Oliver Zangwill and John Ravens, Shapiro actively participated within the CPP MH with regards the role and standards of clinical psychologists working with adults within the NHS (Hall 2007a, 2007b).

Shapiro was responsible for the training of the first post-graduate course for applied psychologists within the abnormal and clinical psychology at the Maudsley and developed the 'single case hypothetico-deductive experimental approach', and was in fact more influential in the development of CP in Britain than the iconic and self-proclaimed creator of British CP, Eysenck (Hall 2007b). Shapiro and other colleagues within the Maudsley were responsible for 'trading' psychological assessments to support psychiatrist's work in turn to allow psychologists' access to patients for clinical research and 'covert' therapy (Hall, 2007b). Hall (2007b)

attributes to this some of the foundations of the development of the Behavioural Therapy tradition in Britain.

The addition of behavioural therapy to the role of clinical psychologist in 1958 also triggered the interest in other forms of therapeutic intervention, such as humanistic ideas (Hall, 2007b). Nevertheless the foundation for the therapeutic work was laid by ‘(...) the already established educational and rehabilitative role in work with children and people with learning disabilities.’ (Hall, 2007b, p. 26)

To conclude, ‘therapy’ would only be mentioned for the first time in 1957 when it was brought up on the agenda of the CPP MH in the form of an issue of regulating the practices of ‘conditioning techniques’ within the health services, reflecting the influence of the growth of Behaviourism and Experimental Psychology theories and techniques and not of the US Boulder model. Direct influence of the American Boulder model was not evidenced by the documentary analysis, although Hall’s further analyses of the background and theoretical orientation of key participants in the development of the profession in Britain (Hall, 2007b) did not discard the possibility that they could have endorsed the model personally.

#### 2.3.8. Clinical psychology profession, de-institutionalisation and legal developments

Cromby, Harper and Reavy (2013) wrote a textbook chapter about the history of the conceptualizations of human distress and intervention practices since Classic times. Although this text suffers from some of the same limitations as mentioned in 2.9.9 (authors are psychologists, history is presented chronologically) this critical historical account includes a detailed description of socio-cultural-religious-economical and political contexts and attempted to reflect both dominant and marginal ideas and practices of each period. Within this general historical review, the practices and professionalization of the psy-disciplines, including British clinical psychology, were explored alongside the focus on the development of the institutions involved in the care of those in distress and the law that regulated them. In general, the authors reiterated many of the findings already mentioned above, however they make

relevant points of significance for this study in terms of applied psychology positioning in relation to psychiatry.

Cromby et al (2013) located the 'moral control management', pioneered by lay people within the 18th Century asylum, as a first psychological model of care. This non-restraining treatment aimed to promote self-control through the promotion of regulated contact of the asylum inmates with the staff and others within the institutions (Cromby et al., 2013). 'Moral control' intervention was adopted by psychiatrists, who alongside their usual physical treatments would '(...) through sheer force of personality, subdue the sufferer and then use other psychological tactics to rescue the insane from their affliction by offering them hope of cure.' (Cromby et al., 2013, p. 29). This would be instrumental for the professionalization of Psychiatry and the development of its dominance within the history of adult mental care (Cromby et al, 2013), as the idea of treatability of mental distress and the professionalization of its management within the institutions would lead to the creation of waves of legislation, e.g. the County Asylums and Lunacy Acts of 1845 and the Medical Act of 1858, legitimising the asylum system of care and putting psychiatrists at its control.

A further development of psychological theories and practices, in the form of psychoanalysis and behaviourism, originated within Europe and US in the period between the 19th and the 20th Centuries. In spite of being known and available, they were not widely used until the return of shell-shocked soldiers from the front of the First World War (Cromby et al, 2013), and this intervention was also adopted by psychiatrists. The authors also attributed the public's increased interest in psychological therapies, in particular psychoanalysis, to the influence of the mass media portrait of the figure of the analyst in a series of Hollywood film plots from 1949 onwards (Cromby et al., 2013). The 1950s saw the right conditions for the development of four new psychological therapies: behaviour therapy, client-centred therapy, family therapy and CBT (Cromby et al., 2013). Behaviourist clinical practices, further developed with the Skinnerian concept of operational conditioning, started to be used on a large scale in institutions in both UK and the US.

Another great contribution to the growth of interest in psychological treatments would be the process of de-institutionalisation. The asylum system in Britain reached its



peak capacity in the 1950s and became very costly to the State. A combination of public exposure of cases of abuse and mal-treatment within the institutions, largely denounced through Goffman's book 'Asylums', the emergence of psychopharmacological treatments, developments of the welfare state and the availability of different forms of community care and rehabilitation, including psychological therapies, all contributed to the conditions for a political drive to change the system of care in Britain (Cromby et al, 2013). The Mental Health Act of 1959 emphasised shorter admission and a reduction in compulsory care, and in 1961 the conservative Minister for Health, Enoch Powell, laid out his plans for accelerating the transfer of care from institutions to the community (Cromby et al, 2013).

As adult mental health care was transformed within the NHS, clinical psychologists' presence within these services would slowly increase over the years and move from a position of supporting psychiatrists' work to become established as providers of a wide range of interventions in their own right, including a variety of talking therapies. Cromby et al. (2013) noted that it was only after the recommendations of the 1977 Trethowan Report that clinical psychologists gained more autonomy because, for the first time, they could receive referrals directly from general practitioners (GPs) independent of the psychiatrist.

The authors also described how the challenges to psychiatric practices in the 1960s led to an increased interest in other explanation for human distress, including the psychological. Although the anti-psychiatry challenges have continued over the years, the neoliberal socio-political context of the 1980s and 1990s, combined with the emphasis on the development of community services and the continued increase in the sales of psychopharmacological medication, meant that interest in non-psychiatric approaches lost some momentum (Cromby et al, 2013). Significant contributions to the renewed challenge to psychiatric theories and practices have been made by British clinical psychologists, such as by Lucy Johnstone, Richard Bental and Mary Boyle to mention a few. This movement which also has participation of critical psychiatrists and service-users groups advocate the search for validity of other perspectives to understand the experience of distress became known as a postpsychiatry (Cromby et al, 2013).

To summarise, the authors described the parallel growth over the last 50 years of non-professional forms of support for those who experience distress as part of the self-help and service user-lead movement (Cromby et al, 2013). ‘Interventions’ such as the ones used by Alcoholics Anonymous, running since 1935, or the Hearing Voices Network, in the UK since 1988, do offer significantly positive support to those experiencing distress. In response to the growing influence of the user movement, Mental Health Legislation in the UK has since the 1960s focused on the restriction of compulsory treatment and in the reduction of stigma (Cromby et al, 2013). Service-user led organisations have been critical over the years about the professional control of mental health services, albeit directed to psychiatrists. Although Cromby et al. (2013) do not discuss this, it remains to be seen how the service-user movement will interact with clinical psychologists in face of the profession’s growing influence and control within services because of large scale CBT delivery, as discussed above, and for the potential of the professionals to become Responsible Clinicians sanctioned by the revision of the Mental Health Act (2007) in 2011.

#### 2.3.9. Clinical psychology as non-reflective and self-limiting practice

Craig Newnes conducted a critical historical analysis of CP in Britain analysing documents. His critical thematic analysis demonstrated how the work of key academics and the theoretical difficulties of explaining ‘the human condition.’ (Newnes, 2014, p. 6) have guided the development of a profession that has deviated from its initial intention of helping people.

Similarly to the historical accounts reviewed above, Newnes (2014) reported that in the context of the conflicted beginning of British CP practice between positivism and psychoanalysis, the scientist-practitioner rhetoric evolved quickly to affirm its place in the NHS, compliantly alongside psychiatry, and to establish its own privileged space within the market of psychological therapies. The influence of the North American CP, because of the inclusion of therapy provision supported by the Boulder model and later by the development of Behaviourism, sustained the British shift to therapy alongside the traditional assessments (Newnes, 2014).

Newnes, explains that the 'eclectic' positioning of CP established after the turn to therapy in the 1960s and the inclusion of experimental, psychodynamic, humanistic and systemic practices, has actually failed in the long run to establish psychological treatment as an alternative to psychiatric treatment. Instead, it took more of a complementary role to psychiatric treatment, and forms of therapy that can be evaluated within a positivist framework, such as CBT, are taken on by the profession and used by social policy makers(e.g. Layard and IAPT), to invert the causality between unemployment and psychological difficulties. To clarify, Layard proposed that CBT would support people who are unemployed because they experience 'depression and anxiety' difficulties (Layard, 2005), disregarding the possibility that unemployment led to psychological distress.

Newnes also concluded, similarly to Rose (1985), that the reliance on statistical methods has an impact on the maintenance of the status quo of psychologists: '(...) a belief in statistical 'normality' and the possibility of generalising findings to whole populations positions psychological researchers as experts who publish results partly to enhance this persona and partly as one way of ensuring continued funding.' (Newnes, 2014, p. 49). He also refers to the problematic use of research and theory within CP without appropriately grounding their development contextually and temporally. He points to the connections some of the key theories used within CP practice and tools, such as IQ assessments, had with the Eugenics movement, as do Hansen et al. (2003) and Pilgrim and Treacher (1992).

Newnes (2014) understood that the lack of actual reflection, of critical and contextual appraisal and of transparency on the range of clinical and academic activities within the role of CP are major reasons for the profession's present position. The use of scientific discourse, encapsulated in the real daily interaction with service users, confirms the established scientist-practitioner rhetoric that limits the possibilities of the professional practice and narrows the scope of interventions.

Newnes (2014) concludes that the recent changes within the profession continue to contribute to a widely non-reflective practice of the profession that fails to attend the local and contextual needs of the public. The changes he has noticed were: (1) the

increased dominance of white female applicants usually from a privileged socio-economical background in relation to the public they attend; (2) the DCP's public positioning against psychiatric diagnosis without insisting that its members should stop making use of them, who instead conveniently remain relatively autonomous in their daily practice despite the institutional drive to follow NICE guidelines; and (3) the continued promotion of the CP role as scientist-practitioners in spite of the very little actual research produced by senior qualified clinical psychologists (the same conclusion reached by Pilgrim and Treacher in 1992 described above).

## **2.4. Grand scale evaluations of clinical psychology in the UK**

In the 1970s, when CP had already established the provision of therapeutic intervention within its repertoire (until then CP practice was mostly related to assessments) the profession was subjected to scrutiny by a series of government-driven reports. It was a period of change within State politics and the introduction of neo-liberal policies of the Thatcher administration led to reforms of the NHS and other State institutions (Pilgrim & Treacher, 1992). For CP it meant that internal debates about the nature of the professional role had to be suspended whilst the profession prepared to explicitly justify and defend its existence.

### **2.4.1. The Trethowan Report**

As part of the Department of Health and Social Security (DHSS), in 1972 the Standing Mental Health Advisory Committee established a sub-committee led by Professor Trethowan to evaluate the role of psychologists within the NHS. This was a response to the queries raised by the Zucherman Committee on Hospital Scientific and Technical Services in 1968, which, while attempting to identify which professions should be part of a new hospital scientific service, could not decide about CP's inclusion in the proposals (Trethowan, 1977). The report identified the contribution that CP could make to a variety of services, including primary and physical care based on responses to questionnaires.

The report's conclusions reinforced the rhetoric of the applied scientist and valued the profession's newly established role in psychological treatment, independently of psychiatric treatment, and its contribution within multidisciplinary teams (Trethowan, 1977). The small number of clinical psychologists was identified as a serious limitation, as the professionals available could not fully use their set of skills and there were no professionals available across the wide range of services that would benefit from CP intervention. The report stated that one of the possible causes could be that psychology graduates would find other areas of work outside the NHS more attractive and stated that this needed to be addressed. Among its recommendations was a further detailed study to evaluate in detail the manpower issues alongside the organisation of clinical psychologists under district psychologists.

#### 2.4.2. The MAS review

In 1986, the Manpower Planning Advisory Group (MPAG), a body formed by the DH and the NHS, was requested by the government and the BPS/DCP to set up a study to evaluate the manpower of CP and its core skills, to inform both services and training institutions. It made use of survey data collected by the DH and the BPS and commissioned the Management Advisory Service (MAS) to review CP services to identify 'Competences and performance standards required within clinical psychology services and the implications for training (...)' (MPAG, 1990, p.5).

The MAS *Review of Clinical Psychology Services* published in 1989 was an empirical study that aimed to identify (1) the need for and purpose of CP, (2) alternative providers of psychological skills, (3) current issues within the profession, (4) service delivery models of CP and (5) to finally estimate how many clinical psychologists would be needed in the NHS. This comprehensive review was considered controversial and was received with caution by the profession at the time (Pilgrim & Treacher, 1992).

There were limitations of this study. Firstly, it was co-ordinated by a clinical psychologist, Derek Mowbray. Secondly, it has only used other members of the

MDT (nurses, OTs, psychiatrists) in comparison with clinical psychologists when seeking to identify alternative providers of psychological skills. It is unclear why it has not included other professionals who would have had training and functions directly involved in the provision of psychological support, such as other applied psychologists, psychotherapists, art therapists or counsellors. Thirdly, in terms of service delivery models, it used a very small selection of developed countries for the Northern Hemisphere: Sweden, Norway, the Netherlands and the USA, claiming that those had established provision of clinical psychology and features that would be interesting to the British services. The criteria for this selection is unclear, it included services delivered in a very different format from the public NHS (e.g. USA) and excluded other countries with a similar context from the UK with also established psychological traditions, such as France, Canada and Australia.

In terms of the clinical psychologists' skills and the scope for the future improvement of services the results of the report were highly positive: CP was identified as a unique and indispensable profession within mental health, physical health and learning disabilities services, for all age ranges, able to contribute clinically with assessments and the delivery of psychological intervention based on a variety of psychological models (though the report emphasised behaviour therapy), to supervise and teach other professionals delivering intervention, to conduct research and service evaluations, to offer consultation to professionals, teams and other services, and finally to support management with occupational and organisational strategic issues.

The profession's move to provide psychological treatment, not only assessment, in a more independent fashion from its historical origins as an auxiliary profession to psychiatry (MAS, 1989), was praised and valued. In comparison to the other providers of psychological intervention (MAS used the professionals of the multi-disciplinary team (MDT) as comparison) CP was seen as the only profession to have skills covering all three levels established by the report: 'Level 1' being establishing therapeutic relationship and providing counselling, 'Level 2' being delivering protocol-based behaviour intervention and 'Level 3' being:

(...) activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw-on a multiple theoretical base, to devise an individually tailored strategy for a complicated presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level, which comes from a broad, thorough and sophisticated understanding of the various psychological theories. (MAS, 1989, p. 6)

It is important to note the context within which the MAS review was making its recommendations; it had made use of the guidelines of the WHO initiative *Health for All by the Year 2000*, and within these parameters, CP was identified as one of the key professions with the ability to contribute to the public in terms of health promotion and consequently contribute to the NHS in economic terms. CP was identified as able to use its research skills to design and deliver preventative and educational programmes to promote changes of behaviour that were, otherwise, highly costly to the NHS (MAS, 1989). It was identified at the time that:

The preventative dimension is grossly inadequate. There is a need for a more primary/prevention-focused service - amongst the “worried well” are tomorrow’s more seriously and chronically mentally ill. Prevention is a more cost-effective alternative to waiting for individuals to become dependent on health services and consequently more expensive to treat. (MAS, 1989, p. 7)

MAS (1989) would use this prevention and cost-benefit argument to advocate an expansion of the workforce and training places: ‘Within the balance of service provision, we recommend that greater resources be allocated to primary care than are currently, in order to introduce the serious possibility of preventing illness and promoting and enhancing health.’ (MAS, 1989, p. 3)

This positive view provided an acknowledgement of the expert claims the profession had been making for years and final recommendations were made to change and expand the scope of the role through: (1) increasing the number of professionals to 4000 new clinical psychologist and (2) increasing the number of training places to 300 a year to achieve a ratio of 2 psychologists per 25,000 population within 10 years. Of the four different options proposed for the organisation of CP services, the consultant-led model was considered more efficient and most likely to be accepted by professionals and services.

It was indeed the one that was eventually adopted by CP and its principles suggested the adoption of the consultancy model would provide CP with equal responsibilities to psychiatry. Implied in this proposal was a vision of changing the title of 'clinical psychologists' to 'healthcare psychologist' and to invest in the expansion of the role into primary and physical care. Once more, just like the Trethowan report, MAS (1989) recommended: '(...) that psychologists become fully independent professional practitioners, accorded equal status with medical practitioners and assuming responsibility for the psychological well-being of individuals served by and providing healthcare.' (MAS, 1989, p. 3).

The report also identified challenges within CP, amongst which were: (1) not having a statutory role; (2) uncertainty with regards to supervising colleagues from the MDT who deliver psychological intervention; (3) unattractive career progression; (4) the poor promotion and clarity around CP's role leads to a sort of 'mystery' surrounding the profession; and (5) the dualist accountability system resulting from the introduction of the general management to the NHS: '(...) whereby psychologists became administratively accountable, through the district psychologist, to a general manager, whilst professionally accountable to the district psychologist.' (MAS, 1989, p. 28)

### **3. A HISTORY OF THE PRESENT**

In this section, a final component of the problematization being constructed in the argument for this thesis is explored: the recent history and context of the CP



profession. Within the rationale for this study is important to contextualise the issues internal and external to the profession in order to present some of the influences and challenges to its practices that will be discussed in chapter 3. To that end section 3.1 lists some of the recent historical changes within the NHS and recent developments within the profession. Section 3.2 introduces some criticisms of the profession of CP. Those criticisms are continued in section 3.3 where some alternative applied practices of psychology and some of the evidence that supports them are briefly described to expose further challenges to the current mainstream CP practices.

### **3.1. Recent contextual changes**

In section 1.2., at the beginning of this chapter, the impact of IAPT on the practice of CP was described. In this section, I return to this recent event and other contextual and historical developments that the profession has experienced in recent times to argue that there is a need to conduct another study about the current professional practice of CP that would account for the impact of those.

Since the publication of the MAS review, the last comprehensive and large scale evaluation of CP, there have been significant changes in the NHS and CP has experienced, amongst other things, the introduction of market competition within the health sector (Rouf, 2006) and the internal consolidation of its professional identity through the distinct use of psychological formulations as one of its core professional competencies (Johnstone, 2006). To be more specific, since 1989 CP has experienced:

1. 1991: the creation of NHS Trusts (1991);
2. 1995: the merger of District Health Authorities (DHA) and Family Health Services Authorities (FHSA);
3. 1997: The New NHS: the creation of Primary Care Groups (PCGs) and Primary Care Trusts (PCTs);

4. 1999: National Institute of Clinical Excellence (NICE) guidelines;
5. 2002: the creation of Strategic Health Authorities (StHAs);
6. 2004: the implementation of Agenda for Change (AfC);
7. 2004: the consolidation of the Foundation Trusts;
8. 2005: the establishment of Payment by Result (PbR) policies;
9. 2006: the creation of larger StHAs and PCTs;
10. 2006: the roll-out and expansion of IAPT;
11. 2007: the proposal of New Ways of Working (NWW);
12. 2009: the regulation of the profession by the Health Professions Council (HPC), that changed its name to Health and Care Professions Council (HCPC) in 2012;
13. 2010: the publication of Equity and Excellence: Liberating the NHS;
14. 2010: changes in the Mental Health Act (2007) with the significant addition of CP to the professions that could train to become Responsible Clinicians (RC);
15. 2011: the abolition of the PCTs and the creation of the GP commissioning system by the implementation of The Health and Social Care Act.

In addition to these changes in the NHS, the coalition government's comprehensive spending review plan (HM Treasury, 2010) aimed to make significant changes to the welfare benefits system in response to the estimated £149 billion structural deficit in 2010-2011. MAS (1989) and Pilgrim and Treacher (1992) have described how a similar context in the 1980s was crucial in re-shaping the professional identity and position of CP within services. The service users seen by clinical psychologists are usually people who rely on benefits and any changes are likely to affect the service user directly, increasing their difficulties and requiring more support from services, such as the one provided by CP (Pilgrim & Treacher, 1992).

A considerable change observed in the background bureaucracy supporting the services is the use of psychiatric concepts and psychological techniques to organise

services and demonstrate the efficiency of interventions. With the market orientation adopted by the Mental Health Foundation Trusts, the use of diagnostic categories within mental health services became almost commodities that are used within business jargon to refer to strategic service organisation. Outcome measures have become incorporated indiscriminately into common daily practice to evaluate the efficacy of any intervention and to provide data for commissioners. Services have become organised into 'care clusters' (DCP, 2013) that aim to control the pathway of all service users and ensure effective service delivery to all. This organisation of services also suits initiatives such as 'Payment by Results' (NHS, 2010b) that creates a performance orientated practice amongst the health workers. Some Trusts have gone even further and adopted care management styles inspired by industrial models of efficient mass production, such as the 'Lean Toyota model' (Snowball, 2012).

In January 2011 key members of CP profession started a debate questioning the directions and future of the profession and its practices. The Clinical Psychology Forum (DCP) of the BPS organised a special edition entitled '*Clinical Psychology Getting Lost?*' (DCP, 2011a) in which several key professionals and professional groups across the country commented on the opinion piece written by Richard Hassal and John Clements (2011) who had raised their concerns about the increased role of CP in delivering psychological therapies. Within this debate, old questions about the origins and functions of the profession were brought to the surface and a split between professionals was apparent. Some authors explicitly shared Hassal and Clements' worries while others spoke about the opportunities that the focus on therapy gives.

In 2013, in response to the publication of the DSM-V of the American Psychiatric Association (APA) **Invalid source specified.**, the DCP published a position statement (DCP, 2013) pointing out the difficulties of using psychiatric diagnostics because of '(...) significant conceptual and empirical limitations (...)' (DCP, 2013, p. 1). Challenging the underlying theoretical assumption of psychiatric diagnosis, the DCP proposed a 'paradigm shift' in favour of using an approach based on psychological formulations.

To end this section it seems opportune to attempt to summarise the differences between the present day CP and the professional practice evaluated by the MAS review, to demonstrate how much the profession has transformed alongside all the contextual changes exposed above. Table I, below, was created making use of the key facts about CP published by Pilgrim and Treacher in 1992.

TABLE I: Changes in key elements of the profession between 1992 and 2014

<b>Summary of the Clinical Psychology profession in 1992 (Pilgrim &amp; Treacher, 1992)</b>	<b>Summary of the Clinical Psychology profession in 2014.</b>
It is a small profession (about 2500 practitioners).	The HCPC has 19,691 Practitioner Psychologists <sup>1</sup> currently registered (Health & Care Professional Council, 2014). The BPS DCP reported that it has more than 9,500 Clinical Psychologists registered (BPS, 2014) (although this number might include those in training and assistant psychologists) which would correspond to almost half (48.2%) of HCPC Practitioner Psychologists.
Its practitioners vary in their approach to their work.	The practice of CP still varies, although CP is now regulated by the HCPC and regulation 2.b.4. states that clinical psychologists ought to be skilled in the delivery of CBT (Health & Care Professional Council, 2014). The practice may vary according to the area of professional practice, i.e. in primary care and adult mental health the focus has been on the use of CBT. Other areas, such as

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<sup>1</sup> This represents the number of Clinical, Counselling, Educational, Forensic, Health, Occupational, Practitioner, Registered and Sport and exercise psychologists.

	people with learning disabilities and children and families CP services have been increasingly using more CBT interventions.
They have peculiar statutory powers delegated by the state.	Clinical Psychology has been regulated by the State via the HCPC since 2009 and according to the amendments of the MHA (2007) in 2011, clinical psychologists can be trained to become RC.
Their only certain commonality is their standardised qualification in higher education, studying psychology to graduate and post-graduate levels.	Although the minimum qualification standards remains the same in terms of the requirements of undergraduate degree in Psychology and a post-graduate doctorate degree in CP, of which the BPS has guidelines on the content of training that are jointly validated by the HCPC. Greater variation is encountered among the trainees in the doctorate in CP courses, some of them already having completed a Masters degree or PhD beforehand (Newnes, 2014).
Their training courses are highly variegated and typically eclectic in espoused philosophy.	Training courses are still varied and have an individual ethos, exemplified by the courses' descriptions within the Clearing House website <b>Invalid source specified.</b> However, recent changes within their curriculum of training determined that trainees must be skilled in delivering CBT as well as another therapeutic modality (Committee on Training in Clinical Psychology, 2013).
They claim an allegiance to science to justify their existence – hence	There has been the addition of 'reflective practitioner' to the 'scientist-practitioner'

there is a strong emphasis on the 'scientist-practitioner' model of practice.	model. Some authors argue that the scientist-practitioner model has become increasingly rhetorical (Newnes, 2014; Pilgrim & Treacher, 1992)
They compete with other professionals who claim similar expertise. (There is no disciplinary monopoly on psychological knowledge.)	Clinical Psychologist's niche in the market for provision of individual therapies has become increasingly more competitive, e.g. within the new roles of the IAPT service model's there is a risk that CP skills are indiscernible from other providers of psychological services. (Centre for Workforce Intelligence, 2012)

### 3.2 Critiques of the positioning of clinical psychology

Some of the recent events, seen in sections 1.2 and 3.1, confirmed an increasingly privileged position of CP within the NHS. In this section some of the critiques the profession of CP receives are combined with some of the findings of the critical historical analyses reviewed in section 2.3 above. The aim of this is to argue in favour of the need to understand the functions, consequences and limitations of the current professional practice as the main rationale for this study.

Critical approaches have emphasised the need to critique mainstream CP to encourage practitioners to reflect on their practices and to consider alternative models. In opposition to the individualistic and alienated CP discourse, authors with a critical psychology stance understand that psychology and politics are inseparable and therefore must always be considered concomitantly to enhance psychology's potential for improving well-being (Fox & Prilleltensky, 1996; Kagan & Burton, 2001).

Historically the increased power of the psy-complex has been based on Cartesian dualism and Eurocentric ideas that locate mental illness within the individual (Cromby et al, 2013; Patel, 2003). Psychiatric diagnoses, as seen above, have also

served to empower psychological treatments (Marecek & Hare-Mustin, 2009; Newnes, 2011; Newnes, 2014). Rose (1985) stated that ‘(...) it was through attempts to diagnose, conceptualise and regulate pathologies of conduct that psychological knowledge and expertise first began to establish its claims for scientific credibility, professional status and social importance.’ (p. 226). Pilgrim and Treacher (1992) have described how CP, in its quest for establishing itself as a profession through claims of expert knowledge, has used a convenient ambivalent positioning either as an accessory profession or as an alternative practice to psychiatry through the years.

CBT, the therapeutic intervention commonly used by CP in the UK nowadays (Committee on Training in Clinical Psychology, 2013), is also based on bio-psycho-social theories and is a problem-based approach that uses psychiatric diagnostic categories to guide its treatment protocols. Thus, alongside psychiatry, CP is possibly an important force in maintaining the relationship between mental illness and the current socio-economic and political context (Newnes, 2014).

### **3.3. Alternatives to mainstream clinical psychology and their supporting evidence**

In this section I add to the critique of CP mainstream practices in adult mental health by describing some of the alternative practices currently available and the emerging evidence that support them. These descriptions will be brief as the analysis of these is not the goal of this study, the main aim here is to demonstrate that there are other possibilities available to CP practice, based on different understanding of human distress and supported by evidence.

Some attempts to address the alienation caused by the narrow use of a bio-psycho-social model of mental health have been endorsed by some of the schools of the critical tradition producing theories and practices that address issues of power, such as: discursive psychology, feminist psychology and community psychology (Fox & Prilleltensky, 1997).

The community psychology movement, although relatively young, diverse and still inaccessible to the majority of the British population (Burton, Boyle, Harris, & Kagan, 2007), attempts to address power imbalance through assessment, formulation and interventions designed beyond the individual level. It enables local groups of marginalised minorities to engage in social action. An example is the work of Sue Holland (1992), who found that this approach not only served to alleviate individual psychological distress but also to empower the local community.

Community psychology became a new section of the BPS in 2010 aiming to become more influential, to question individualistic practices and to build on its evidence base (Lewis & Law, 2011). There seems to be an increasing trend for CP to adopt some community psychology values and practices (Cheshire & Pilgrim, A short introduction to Clinical Psychology, 2004; Newnes, 2014). Moreover, Higher Education (HE) institutions have been organising and making available more masters programmes in community psychology (e.g. UEL and Brighton University). Community psychology has been indeed the kind of praxis that opposes the current CP practice (Newnes, 2014).

Recent research has found reliable evidence to support some critical psychology theories, such as Smail's (2005) social-materialist theory of psychological distress. In a World Health Organisation (WHO) report (2009), Friedli identified mental health as key to the resilience and well-being of individuals and communities when faced with adverse conditions. She also described the relationship between material inequality and mental health and concluded that public policies and programmes should focus on whole populations because there is a need to understand the role of social inequalities and mental distress at a community level.

Wilkinson and Pickett's (2010) epidemiological research confirmed the findings of WHO (2009). They went further and demonstrated that social problems, such as mental illness, are worse in unequal societies which can be considered as evidence for critical community psychology practices that understand that psychological interventions delivered at an exclusively individual level are not enough to address the complexity of the social reasons underpinning the emergence of mental illnesses. Wilkinson and Pickett (2010) argued that these problems are related to



wider issues such as loss of community values and social stigma. They recommended that to address mental health and social problems in a more permanent and meaningful way it would be necessary to empower communities, improve conditions of employment and reduce income inequality.

In spite of all this evidence and the available alternative practices, CP continues to value its traditional ways of attending to individual issues within medical models. Despite her current prominence the professional psychologist appears not to be empowered to advocate for a broader social approach (Newnes, 2014). It appears that the contextual knowledge gained within their professional expertise and training is not necessarily used to inform their practice and it is not even clear how the majority of clinical psychologists consider and integrate these wider social influences in their clinical work (Thompson, Exploring the trainees' view of socio-political approach within UK clinical psychology, 2007). It is worrying that the routes by which professional psychologists inform government, businesses and even other academic disciplines are rather limited by an evidence base dominated by quantitative research methods that do not necessarily reflect the realities professionals encounter when attending to the public (Newnes, 2014).

Hansen et al. (2003) stated that psychologists avoid facing the reality of their own history, and proposed two explanations: (1) that this may be caused by the discipline's difficult past connections with Eugenics and Fascism and (2) because of the limitations of its theoretical base, mostly aligned with the reduced options left by a Cartesian dualist understanding of the experience of being in the world. Boyle (2011) also stated that CP avoids looking in depth at its own roots and the real impact its practice has on the overall social understanding of mental distress.

### **3.4. The need for a history of the present – summary and rationale**

This chapter has so far problematized some of the issues that CP currently faces. In this section there is a summary of the literature review, recommendations for future research and these are connected with the needs of the present context of the profession, reflecting the changes (described in section 3.1, the latest critiques of CP

described in section 3.2 and the contrasting of alternative forms of applied practice and their supporting evidence in section 3.3.) The aim of articulating these is to provide a clear rationale for this study and the research questions formulated in section 3.5 at the end of the chapter.

In summary, the historical studies reviewed in section 2.3 above, identified that CP professionalization in the UK has been influenced by: (1) the developments in the way in which the institutions where clinical psychologists worked conceptualised and intervene with those experiencing distress (Cheshire & Pilgrim, 2004; Cromby et al., 2013; Hall et al., 2002; Hall, 2007a; 2007b; Hearnshaw, 1964; Newnes, 2014; Pilgrim & Treacher, 1992; Rose, 1985) in particular from the point of creation of the NHS (Hall, 2007a; Pilgrim and Treacher, 1992). (2) It was also found that CP has been influenced by changes within psychiatry which historically has been a more dominant profession within adult mental health (Cheshire & Pilgrim, 2004; Cromby et al., 2013; Hearnshaw, 1964; Newnes, 2014; Pilgrim & Treacher, 1992; Rose, 1985) (3) Developments within CP's professional body the BPS and a public demand for psychological therapy have been great influences in the professionalization of clinical psychology (Hall et al., 2002; Hall, 2007a; 2007b; Lovie, 2001; Thomson, 2001).

The recent ascension of IAPT and formalisation of clinical psychologists' CBT skills claims (section 3.1), alongside increased criticism about the professional practice of CP (section 3.2), the availability of alternative forms of practice and evidence supporting these on-individualistic practices (section 3.3.), would make it necessary and relevant to re-explore the professional history of CP in the present time.

Cheshire and Pilgrim (2004) and Newnes (2014) were the two studies that looked at some of the impact of the recent contextual changes within CP. Although they both revealed many aspects about how the profession of CP interacted with their wider system, institutions and implemented changes, they did not focus on looking at the discursive constructions in use by the profession to make these negotiations.

In addition to this and to further justify the importance for the conduction of a discursive based study is the argument that the knowledge about the history of the professionalization of CP would enable the professional to improve their practice according to the concepts of Foucault which are described in detail in Chapter Two.

Hall et al. (2002) had identified the need to conduct more historical analyses to provide resources for practitioners to feel empowered. They observed that '(...) the profession has been short of self-doubting and sometimes lacerating self-analysis (...) The significance of the personal values and ethics of psychologists, which were never even considered in early times, have emerged as a major area of discourse. Has the adoption by clinical psychologists of the trappings of formal professionalism primarily benefited those who use their services, or those psychologists themselves?' (Hall et al., 2002, p.45).

Another example is how Pilgrim (2010) also advocated for the need to teach trainees and professionals about the social history of CP and although some courses take on this challenge (Harper, 2010) the teaching of professional history and epistemology is still not mandatory on training courses (Committee on Training in Clinical Psychology, 2013). Bunn (2001) argued that, within the current understanding of how the history of psychology can be studied, through a series of distinct investigations limited to certain places and times, such as a particular technique or a person, historical analyses can contribute to the development of the discipline as much as their traditional quantitative and qualitative studies.

To conclude, the recommendations of Hall et al (2002), Pilgrim (2010) and Bunn (2001) add to the justification for the need to continue the historical study of the profession as its findings would aid clinical psychologists to become more aware of how their professionalization process may limit their practice as identified by Newnes (2014).

### **3.5. Research questions**

Based on the identified need to continue developing the historical knowledge base of the profession of CP, seen in section 3.4, to challenge and explore the recent changes of the professional practice, seen in section 3.1, it seems to be relevant and opportune to identify the possibilities for the profession in the UK to incorporate into its practice the evidence of the influence of social inequalities on the development of human distress and some of the available alternative practices, seen in section 3.3. We will attempt to do this through answering the following questions:

1. How did Clinical Psychology professional practice in adult mental health become increasingly focused on the provision of psychological therapy despite the suggestions of the MAS review in 1989?
2. What are the dominant discursive themes of current professional practice?
3. What are the contingencies that inhibit CP from considering indirect practices focusing on health prevention and promotion?

## **Chapter Two: METHOD**

This chapter describes the method used to conduct this study: a discursive thematic analysis (DTA) informed by the concepts of Michel Foucault. It will firstly clarify the epistemological stance adopted by this study. Secondly, it will briefly describe the key concepts of Michel Foucault, including his conceptualization of discourse, history, genealogy, archaeology, power, knowledge and institutions as used within the analysis. Thirdly, it will describe how this specific DTA combined with the concepts of Foucault. At the end of this chapter, I will clarify the practical and analytical steps followed, including the description of the collection and selection of the texts used as data.

### **1. CRITICAL REALIST SOCIAL CONSTRUCTIONISM**

In Chapter One I described how the recent literature on analysing professions recommends that a post-modernist and contextual approach is used to take into account the plurality of systems which influence the professionalization process. As the research questions are about the development of the profession of CP within a recent period of its history (question1), the professional discourses of its current practice (question 2) and the contingencies that have influenced them (question3), the concepts and methods used by Michel Foucault were identified as providing the best theoretical basis to support this research because they would cover the historical dimension of the analysis.

Following the above, this study has adopted a critical realist social constructionist epistemological stance as expected when making use of Foucault's methods and concepts (Harper, 2012). It understands that in the real world, composed of natural phenomena, inhabited by bodies and objects, human beings live within societies in interaction with one another and the natural world. In these interactions they communicate and use a set of practices which create meaning as a way to explain, organise and classify both social and material worlds. Within a specific historical time people make use of and share the same system of meaning that defines the

world they inhabit; people will always use their resources within the existing discursive formations.

A critical realist social constructivist epistemological position assumes that knowledge is not only constructed through the social interactions but that is also bounded by organised systems of meanings which are temporal-spatially specific. Social construction is therefore somewhat limited by the operations of the discourses according to the theoretical concepts of Foucault's that are explained further in the following section.

## **2. FOUCAULT'S CONCEPTS**

### **2.1. Discourse**

Discourses are the mechanisms by which representations about things and experiences in the real world are made, the means by which practices, subjects, objects and knowledge are produced (Kendall & Wickham, 1999). Their production is regulated and systematised by a series of rules that limit what can be said and represented (Foucault, 1981). Discourse is 'pure thinking' (Kendall & Wickham, 1999), not in terms of cognitions but in its immateriality, although its operations provide the material means by which we make sense of the world. Discourse cannot be simply reduced to be the equivalent of expressed language (Foucault, 1981) as Foucault explains that what is not said also reflects something about the discourse being used (Foucault, 1972). Discourse is the operation by which thoughts and communication are made possible, through setting the parameters for these representations.

Foucault (1981) does not see the possibility for a material world to exist outside a discursive domain as it is indeed in our attempt to interact with the material world and to control it that we create meaning. That is to say, in referring to any aspect of the material world, at any one time, people have to make use of some sort of pre-established symbolic representation, through language, which already contained a shared meaning. Foucault (1981) understood that we live in a world where natural

phenomena and chance are seen as dangerous and risky and to manage life within social groups we need to create a series of practices to attribute meaning to the natural world. Discourses are strategies used to control the real world and for Foucault the discourse, that is formed historically and in a social context, emerge within a situation in which many different macro societal changes are happening and only rarely from the need to understand, describe or act upon something new. Once accepted by the operations that will be described below, in section 2.1.1, discourses are used extensively over a period of time and eventually become as if material and inflexible. In other words, this means that the original context in which it was used within the specific situation to attribute meaning is forgotten.

Because of these mechanisms of organisation of discourses, explained in detail in section 2.1.a below, Foucault (1972) concludes that discursive formations are commonly used by the people who live within the same society in the same historical time and do not have an identifiable author or authors. Even when some discourses seem privileged and dominant in relation to others, the oppositional and subjugated discourses are also part of the power play within the discursive formations of a time.

Discourses are more than language and relate to the forms of knowledge that are valued within a society within a specific historical time, conceptually it is not possible to attribute different interpretations to them, they are considered to be fixed for the purpose of a historical analysis. Discourses are what they are, reality is not flexible and relative from the eyes of a particular observer (Rabinow & Dreyfus, 1983). Within this epistemology and Foucault's concepts, things do not have an inner essence (Rabinow & Dreyfus, 1983). There is no hidden meaning to the things we observe or experience, no unconscious nor underlying motivations to be discovered either, the things are as they appear on the surface (Kendall & Wickham, 1999; Rabinow & Dreyfus, 1983). Truth is constructed socially and is historically specific, through many strategies that include defining subjects and objects, establishing practices, knowledge claims and operations of power.

### 2.1.1. Rules of organisation of discourses

In his inaugural lecture at the *Collège de France* in 1970 (Foucault M. , 1981) Foucault explained in detail that discourses have external procedures of exclusion, internal procedures of organisation and rules of accessibility that are often found working concomitantly. As some of these rules of organisation of discourses were used to identify and analyse the discursive themes within this study, they are summarised here.

Referring to procedures of exclusion, Foucault discussed how the prohibition of what can be said and done in certain occasions and by certain people qualifies certain representations. Paradoxically, prohibitions do actually generate more interest and power to the discourses being forbidden. The division of meaning into two opposing positions, such as good and bad, madness and sanity is another form of exclusion. One of the most influential forms of exclusion in the formation of discourses since Classical times and reinforced since the industrial revolution, is the Positivism discourse, in which there is a dichotomy of knowledge between truth and falsity, truth being considered superior.

For internal processes which order and limit discourses, Foucault discussed the hierarchical organisation of texts, the role of the author and the role of protection by closed societies. The discourse contained in original texts, is maintained in a relationship of superiority by secondary sources that in the attempt to modify them end up repeating them. In terms of the author, both scientific and religious discourses value the authority of certain names because of their qualification or role within specific societies (this is a key point in this research and I will return to the question of the author in section 3.3 when I describe the choice of data). Foucault also discussed how the division of knowledge within specialised disciplines, in which the development of theory limits what is part of each one's own knowledge, perpetuates what can be included within their discourse as a closed system.

Accessibility is the final component of the organisation of discourses. Similarly to the question of authorship, the qualification of the speaker must be acknowledged and recognised by certain formalities therefore limiting those without them from



commenting on what they say. Specialised societies, organisations (such as professional organisations), institutions, sects and doctrines have the privilege in accessing, controlling and proliferating what is part of their domain. A final and very clear organising rule is the valorisation of certain discourse through the social appropriation of them. This social appropriation happens through the formalisation of the proliferation of certain discourse within educational systems, when they are repeatedly presented fixed in rigid formats that excludes those who do not have the recognised knowledge to differ from or alter them.

To conclude this section, CP professional practice within this study was understood as one of the forms of controlling the natural world in our organised society that creates meaning and shares the common discourses. CP is a formal discipline of knowledge which is taught; it is a professional practice with an exclusive professional body which has an internal hierarchical organisation and clinical psychologists in the UK mostly work within institutions. Considering the rules about the formation of discourse summarised in this section, it can be considered that CP produces and internally protects discourses that attempt to explain the real world. Because of the knowledge boundary of CP, this academic and professional practice produces meaning about other people's experiences and about processes to interact with them, which will be described further in section 2.3 below, when the operations between power and knowledge are described.

## **2.2. General history, genealogy and archaeology**

As mentioned at the beginning of this chapter, history, and its influence on the construction of the social world, is central within the work of Foucault. In this section I summarise how he conceptualised general history and its analysis through the genealogy and archaeology methods, which informed this study.

Based on the French post-structuralist and historiographical tradition (McHoul & Grace, 1995), Foucault adopts a General History approach in which he explores in detail the context and the contextual relationships of the specific historical time. He does that as he opposed the misleading Total History approach (Dean, 1994;

Kendall & Wickham, 1999) in which order and stratification of History under generalised over-arching themes excludes the complexity of all the different subjugated and rare practices that may have played a significant role within a period. Genealogy is an analytical tool that applies the general history principle to reveal the different and less common practices within a period and contrary to simplifying history, it actually exposes complexity (Rabinow & Dreyfus, 1983).

Genealogy was the method used by Foucault in the later part of his work, such as in *Discipline and Punish* and *The History of Sexuality* (Rabinow & Dreyfus, 1983). Genealogy is a study of what is exposed on the surface of the things, exploring the description of the things and practices, their definitions and the words that were actually used. Genealogy does not aim to look for hidden meaning, circular references nor phenomenological interpretation. It is based on a rigorously critical and analytical framework as Foucault adopted the post-Kantian position in which he saw that the responsibility of the philosopher was to locate understanding within the historical times and not find meaning (Foucault, 1983).

Therefore, genealogy is a non-interpretative and non-anthropological analytical method (Kendall & Wickham, 1999). It seeks 'subtle contours and minor shifts' (Rabinow & Dreyfus, 1983) on the surface of the events, i.e. it compares the actual words and descriptions made as they represent the discourses shared at a time they were used in the search for discontinuities and recurrence of social practices and discourses through history. It aims to identify and isolate particular events from their context to then analyse them in depth looking for the longer continuities or discontinuities of social practices (Rabinow & Dreyfus, 1983). For example, Rose (1985) was able to demonstrate using genealogy how the discontinuity of discourses were more informative about the origins of applied psychologies than the orderly, chronological and traditional historical enquires.

The result of a genealogy is a description, a written account that explores the details encountered in texts. These detailed accounts inform us about social practices, how they conceptualise their subject and objects, how embodied beings become subjects in a determined period and locality through certain practices. They are then compared to previous practices and the differences and similarities between them

are discussed. Although finding the origin of a discourse or set of practices might be a result of a genealogy (because it traces the historical trajectory of the conceptualisations), this is not the main aim of a genealogy. The main aim is to put history in motion, which is done by comparing the present to the past, to understand the trajectory, which is what in fact explains the present (Foucault, 1984).

As a genealogy focuses on the description of the trajectory to explain present practices, its refinement is possible through a different analytical process that Foucault called Archaeology. Archaeology would have the function of an in depth investigation of the claims made by a Genealogy, through analysing a specific discourse, exploring further how the discursive domain was formed, in a way 'purifying' the genealogical search (Rabinow & Dreyfus, 1983).

Archaeology is the analytical method that Foucault developed to identify and order discourses and their rules (Foucault, 1981). It aims to differentiate one discourse or practice from another through the identification of the particular set of rules used exclusively by each discourse or practice that defines and delimitates them. Kendal & Wickham (1999), making use of Foucault's lecture on *The Order of the Discourse* (Foucault M. , *The Order of Discourse*, 1981), synthesised seven steps involved in the conduction of an archaeological analysis:

- 1 to chart the relation between the sayable and the visible;
- 2 to analyse the relation between one statement and other statements;
- 3 to formulate rules for the repeatability of statements (or, if you like the use of statements);
- 4 to analyse the positions which are established between subjects – for the time being we can think of subjects as human beings – in regard to statements;
- 5 to describe 'surfaces of emergence' – places within which objects are designated and acted upon;
- 6 to describe 'institutions', which acquire authority and provide limits within which discursive objects may act or exist;

7 to describe 'forms of specification', which refer to the ways in which discursive objects are targeted. A 'form of specification' is a system for understanding a particular phenomenon with the aim of relating it to other phenomena.' (p.26)

Foucault realised that a complete analysis of the socio-historical construction of a discourse or practice would have an initial genealogy followed by an archaeology and another genealogy at the end (Kendall & Wickham, 1999). The way that genealogy makes archaeology meaningful and connected to the present is by adding the analysis of power to the analysis of discourse. It shows how power relations have aided the development and sustainability of certain discourses. Genealogy is used '(...) as a lens through which to read discourses.' (Carabine, 2001, p. 276) and is concerned with the '(...) processual aspects of the web of discourse – its ongoing character.' (Kendall & Wickham, 1999, p. 31). Paying attention to the processual web of discourse means analysing the power of the discourses, through the observation of how discourses relate between themselves, which ones offer resistance or alternatives and even which discourses are not present or have succumbed, and the knowledge claims made by dominant discourses to strategically perpetuate their dominance (Kendall & Wickham, 1999).

Figuratively, the genealogist could be seen as a diagnostician who locates the points of interplay between power, knowledge and the body (Rabinow & Dreyfus, 1983). 'The play of forces in any particular historical situation is made possible by the space which defines them. It is this field or clearing which is primary.' (Rabinow & Dreyfus, 1983, p. 109) Within this field, this space, where social practices and discourses occur and define objects and subjects, 'battles' as in social manoeuvres take place to clear the space. This is a repetitive 'play of dominations' that make way to an 'emergence of a structural field of clashes' (Rabinow & Dreyfus, 1983, p. 110). This play of dominations is fixed in meticulous rituals of power that is another concept key to the genealogy method as it localises and specifies how power works and what it does. 'The rules and obligations which emerge from these rituals are inscribed in civil law, in moral codes, in the universal laws of humanity that claim to temper and prevent the violence that would supposedly exist without their civilizing constraints.' (Rabinow & Dreyfus, 1983, p. 110)

### 2.3. Power, knowledge and institutions of the State

As I have presented in the previous section, genealogy can be understood as an analysis of power. Foucault explained that in his studies about the objectification of the contemporary subject he found that subjects were not only put in relationships of production or of signification (as it had been previously formulated by economics and linguistics theories) but they were also part of very complex relationships of power (Foucault, 1983). Therefore, the analysis of power came to the forefront of his research and genealogy was the method he found to investigate it.

Foucault abandoned the use of theory and instead used an analytical strategy based in critical thought, a few theoretical concepts and an obstinate verification throughout the analysis of its internal epistemological coherence (Foucault, 1983). He understood that using a pre-established theory of power would naively and inevitably serve to establish another subject *a priori*, adding a biased circularity to the analysis itself and not reaching the result of understanding how these were formed (Foucault, 1983). Instead, Foucault uses the following conceptualisation of power:

It seems to me that power must be understood in the first instance as the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organization; as the process which, through ceaseless struggles and confrontations, transforms, strengthens, or reverses them; as the support which these force relations find in one another, thus forming a chain or a system, or on the contrary, the disjunctions and contradictions which isolate them from one another; and lastly, as the strategies in which they take effect, whose general design and institutional crystallization is embodied in the state apparatus, in the formulation of the law, in the various social hegemonies.(...)  
power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one

attributes to a complex strategical [sic] situation in a particular society. (Foucault, 1978, p. 92)

Foucault bases this concept in a new form of political power established by the State since the 16<sup>th</sup> century: the 'pastoral power' that combines in the political structures of the modern State both individualisation techniques and a totalisation of procedures (Foucault, 1983). Salvation in this world became focused on individual health, well-being (which is understood in terms of personal wealth and general standard of living), security and protection against accidents. Salvation within these terms can be offered by State institutions or private market initiatives (also supported by the way the modern State is economically structured) such as medicine, welfare systems, charities, the police and family services (Foucault, 1983).

Within Foucault's post-modern thinking, the State and societal institutions would have a role of controlling and normalising human beings through the individualisation of their needs and the provision for them on mass. Some of these mechanisms have been defined as 'political technologies of the body' (Rabinow & Dreyfus, 1983). In Foucault's work, he identified a series of practices imposed on bodies that demonstrated the wider functions that the State plays (Foucault, 1977). This is a micro-analysis of power and serves to identify an intersection between power relations, knowledge and the body, as '(...) the body is the place where the most minute and local social practices are linked up with the large scale of organisational power.' (Rabinow & Dreyfus, 1983, p. 111)

In the post-enlightenment era, Foucault argued that supporting the dominant practices in the play of power-knowledge would be ultimately a combination of 'scientific objectivity and subjective intentions' (Rabinow & Dreyfus, 1983, p. 108). Power and knowledge are mutually dependent as knowledge informs power and power makes possible the integration of knowledges (Kendal & Wickham, 1999). Knowledge, if recognised as formal and official discourse, such as the scientific discourse, according to Foucault, can be used to choose power techniques that allow it to control a certain domain of practices and perpetuate in this way their discourses. For example, governance is a power technique of knowledge, that legitimises the production of statements, defines rules and practical actions,

therefore perpetuating certain discursive formations (Kendal & Wickham, 1999). Science in the modern world has become established as a wide and powerful domain of knowledge.

It is the role of a genealogy to expose these and challenge the naively positivist ethos of the dominant discourse. Indeed it is in the analysis of the resistances, of 'specific rationalities' that these can be found: '(...) to find out what our society means by sanity, perhaps we should investigate what is happening in the field of insanity.' (Foucault, 1982, p 211). And genealogy also brings an exit, an escape route from these ways of living in which alternative 'subjectivities' are possible to be lived escaping the control and limitations of the individuality that has been imposed as the norm.

### **3. SYSTEMATIC BASES FOR ANALYSIS**

#### **3.1. Discursive thematic analysis**

A Discursive Thematic Analysis, following the guidelines from Braun and Clarke (2006), was adopted to systematise this research. Braun and Clarke (2006) argued that a Thematic Analysis (TA) research method is compatible with a critical realist socio constructionist position and were very explicit about the method's ability "to unpick or unravel the surface of 'reality'" (Braun & Clarke, 2006, p. 81). TA is a basic qualitative methodology that involves the search for patterns within texts, be that actual written material or a transcription of speech.

How the information found in the texts is conceptualised is a key aspect of a DTA. Discourses, as seen in section 2.1, were defined as established forms of organised meaning used by individuals within the same societies over a specific period of time. Therefore the method of searching for patterns and groups of information within the same professional group, that would use discourses that have a shared meaning and understanding amongst them, is compatible with the search that is done in a TA. Moreover, as discourses are conceptualised as in interaction with one another in relations of dominance and subjugation which depend on the play between

knowledge and power, organising a relationship between discursive themes and sub-themes is also compatible within a TA.

In summary, following a series of readings of the data set (detailed information about the data used is found in section 3.3 below) observation of common and repetitive information is grouped and re-grouped in themes and sub-themes in a way that a relationship between them is defined. As seen above, the concepts of Foucault are compatible with the search of repetitions, recurrences and deviations from the way people refers to and explain the real world. The conceptualisation of discourses and their investigation also assumes that what is described by the actual words in texts is what is supposed to be analysed, as no hidden or underlying meanings exist.

To conclude this section, the search for discursive themes, sub-themes and their relationship of dominance and subjugation of the present professional practice of CP would answer the second research question of this study directly. The identification of the contingencies that inhibit CP from considering indirect practices focusing on health prevention and promotion, stipulated by the third research question, can also be answered through the analysis of the relationship between the discursive themes and subthemes. In the next section I explain further how this DTA was adapted to the Foucauldian method of genealogy and archaeology to answer the first research question.

### **3.2. Applying Foucault's methods within the analysis**

Following the concepts described above, this DTA aimed to use some genealogical and archaeological techniques in an attempt to 'diagnose' the microphysics of power of CP: how its institutions (BPS, DCP, HE, etc) and the apparatus of the state (DH, NHS, HCPC, IAPT, etc) intervened with themselves and the public to create their objects of professional practice and the subject of the service-user. Clinical psychologists, through their everyday social practices, were considered to be part of 'meticulous rituals of power' and one of the 'political technologies of the body' of our current society. CP professional practice within adult mental health in the UK was isolated as a specific social practice to be analysed, therefore by studying its



practices and discourses it is possible to localize their power and understand how they operate. This is not an original idea, Foucault and other Foucauldian scholars, such as Nikolas Rose, have identified Psychiatry and its allied practices, which include CP, as technologies of the self. The kind of subject produced through the way professionals objectify and interact with embodied human beings in their everyday practice is the starting point for this Foucauldian informed investigation.

In practice this meant that the genealogy and archaeology methods were used at multiple levels. At one level, respecting the principle of general history and understanding the potential for the analysis of the power play between discursive domains, this study focused on gathering data from the period between 2010 and 2014. During this period the profession of CP in the UK was caught up in the socio-politico and economic turmoil as described in Chapter One, which have lead to structural changes of the major State institution that it is part of, the NHS. Using Foucault's concepts, this period was identified as a structural field of clashes.

At another level, after discursive themes were identified by the DTA, principles of genealogy were applied to identify within each data item how the dynamics of power were established between the different discursive themes within them. As the main aim of a genealogy is to put history in motion (Foucault, 1984), a comparison of the present discursive themes to the past discursive themes was undertaken to understand their trajectory to explain the present practice of CP.

At this level archaeology was used to differentiate one discursive theme from another and to add more depth to the relationship observed between them. This was done using Foucault's principles of organisation of discourses, systematised by Kendal and Wickham (1999) mentioned in section 2.2. At this stage investigation of the discursive themes identified how the profession of CP was describing their practice and the consequent construction of its subjects. Genealogy was once more put into practice to compare this with alternative forms of practices to analyse the power play between the discursive formations and their on-going process of organisation. The final result of this analysis was a description of the trajectory and relationship of power between the discursive themes that answered the first research

question about the historical development of the profession of CP within the adult mental health area since the publication of the MAS review in 1989.

### **3.3. Data**

This analysis of CP made use of documentary material developed by clinical psychologists and their related institutions. The archive of the profession, the data corpus, was considered to be a variety of textual and oral information used by, and aimed at, professionals, stakeholders, media, trainees, training institutions, service users and the lay public between 2010 to 2014. These included professional guidelines, policies, debates and speeches. A challenge to the data collection of a history of the present was defining when the present time would stop. This was relevant to this study because within its extended period of production, successive waves of data collection took place to represent professional developments. For example, the publication by the DCP of a position statement about the use of functional psychiatric diagnosis was published in 2013 and this was considered to be a significant event and deemed to be part of the analysis as well as other documents produced at the time. From this very large amount of information a smaller data set was identified and analysed within these period as it is clarified in this section.

All of the documents used in the analysis were publically available, therefore no ethical approval was required in conducting this study as no individual person, nor group of people, was interviewed for the purpose of data collection. Informal consultation in relation to sources of texts took place in supervision and in one occasion I consulted Professor Peter Kinderman, chair of the DCP in 2011, because of his position within the institution during the period covered by this analysis. Being aware of this research, he referred me to documents that were available online, such as the transcript of one of his speeches (Kinderman, 2011c) and the BPS DCP document 'Core values and philosophy' of the profession, both of them used in the analysis.

As mentioned in the previous section, this analysis has identified as a 'structural field of conflict' the turmoil caused within the profession of CP by the changes stipulated

for the NHS in the Health and Social Care Bill (2011). Following the Bill's publication the DCP division of the BPS hosted a colloquium to discuss the possible implications of the proposed changes to CP and to discuss the position the DCP would publicly take in relation to it. I recorded the presentations and debates of the colloquium and produced a transcript of this event following the guidelines proposed by Banister et al. (1994) that I used in this analysis. The transcription conventions adopted can be found in Appendix I. The transcript of the colloquium was used as the primary source of data by this study because of the opportunity it provided of bringing a live debate between clinical psychologists interested in the profession response to wider institutional changes.

This analysis was followed by looking for the ways that British CP defines itself. The main textbooks analysed were the latest available ones that aim to inform graduate psychologists or undergraduate students about the profession of CP in the UK. These were identified through the consultation of reading lists of doctoral programmes. Most of the documents were accessed through the BPS website, the university and British libraries. Contextual information from the government and DH were also accessed from the internet.

A list of the data set used and a brief description of each data item is found in a table in Appendix IV. These were chosen because they gave an overview of how clinical psychologists understood and presented their work practices to themselves and others. The BPS, the DCP, and the texts produced by the professionals in leadership roles within these societies, were particularly relevant to this analysis of the present because of the official position they hold in communicating on behalf of the profession. In addition, previous authors within the history of CP have stated that: 'Papers and publications from the BPS and BPS sub-systems are major sources for any history of clinical psychology in Britain.' (Hall et al., 2002, p. 32)

A key research decision with regards to the data was who to consider as speaking on behalf of the CP professional practice. Using Foucault's concepts of discourse, the rules of organisation of discourses and the roles of institutional practices within our society described above in section 2.1.1, I have considered it to be of less

relevance to single out particular individuals as responsible for the production of the discursive themes identified within the data set. Importance was attributed to those who produced statements from privileged positions within the societies and organisations that conceptually exert some control over the production of statements according to the theory of discourse,

### **3.4. Process of analysis**

After the selection of the texts a slow reading process began in which the following questions, which were developed by the author as a way to represent some of the theoretical concepts of Foucault described above, were kept in mind at all times:

- (1) What is the definition of the professional practice? What are the discourses used by it?
- (2) What is the object of this practice/discourse, how is it constructed?
- (3) What does this construction mean for the subject?
- (4) In which way this practice or discourse opens or closes the possibilities for that subject?

Following the guidelines in Braun & Clarke (2006) on conducting a DTA, I initially made notes in the margin of the texts describing what they were referring to, trying to answer the questions above. A worked sample of the colloquium transcript, including my initial notation in the margins can be found in Appendix II. At the end of this stage many texts were excluded from the data set because they did not provide any information related to the questions above, i.e. they did not define CP, nor any aspect of its professional practice.

In the second stage, similar notes were grouped and texts from this consolidated data set were re-read and further notes were made. Discursive themes were then identified and started to be grouped together. Initially the group contained a larger and unrelated number of discursive themes as it can be found in Appendix III.

In the third stage, to organise the relationship between the themes and sub-themes, each data item was re-read to understand how the arguments in use positioned themselves in relation to other arguments within the same text, e.g. the positioning and order of statements being made within a speech. In this stage some of the genealogy method was used to identify the relationship of power between the discursive themes and archaeology to identify specific rules of organisation of the sub-themes within the major discursive themes.

These discursive themes and sub-themes were then linked, revealing the connections between them, and, using some of the concepts of Foucault described above in section 2.1.a, their operations of inclusion and exclusion were identified. More evidence of the supporting discourses was sought in the texts, refining the selection of the data extracts that were actually used in the analysis. In the final stage data extracts from different items which made use of the same discursive themes were finally grouped as they can be found in chapter three.

In Chapter Three the discursive themes and sub-themes are presented, analysed and discussed. Within the discussion a comparison between the current discursive themes and sub-themes was made with the themes identified in previous historical studies of the profession that were described in the literature review in Chapter One, sections 2.3 and 2.4.

#### **4. EVALUATING THE QUALITY OF THE ANALYSIS**

Spencer and Ritchie (2012), provide helpful guiding principles to check the quality of a qualitative study through verification of its contribution, credibility and the rigour of its conduct.

In terms of contribution, this study was carefully designed to provide further information about the influences in the current professional practice of CP in the UK. Using a post-modern approach and Foucault's theories and methods, the unravelling of the influences of the socio-historical process of formation of the profession can aid clinical psychologists in being more reflective when conducting their daily practices,

as mentioned in Chapter One, section 3.4, and in this Chapter in section 2.2. The current period of socio-economic turmoil has been shown to affect the profession and the internal debates about the direction the profession has taken in recent years makes this kind of contribution particularly valuable and relevant.

The credibility of this study is demonstrated by the clear account of the research process including how the data was selected and analysed as seen in sections 3.3 and 3.4 above. Care was taken to search for documents from a variety of sources, and the analysis aimed to triangulate data items from different perspectives: (1) from debates within the professionals, i.e. the transcription of the Colloquium and information provided by the DCP chairs within the time period studied; (2) information to the public provided by the BPS; and (3) from textbooks used by trainees and clinicians. Longer data extracts were presented to illustrate not only evidence of the discursive theme identified but also to illustrate the relationship between different discursive themes and historical contingencies and how they are organised.

Rigour in the conduct of this study was demonstrated by continuously checking that the data and analysis were viewed within the methodological assumptions made above throughout this chapter. To minimise researcher bias and avoid excluding valuable sources of information, a few other steps were taken. Firstly, to ensure that the history of the present method is valid the research questions were kept consistent with principle of general history as they problematised a social practice in the present (British CP) and its increased focus on individualised internal problems rather than the social causes of human distress.

To reliably explore the history of the present practice of CP I have followed the two fundamental rules of using Foucault's methods according to Kendal and Wickham (1999): (1) I adopted a sceptical position and (2) I constantly verified that I searched for the historical roots of the discursive themes identified. . This meant that I have avoided making second order judgements when analysing the data and did not look for hidden meaning, keeping the analysis within the surface of the discursive themes identified. I have also avoided making simplistic cause-effect assumptions and I have accepted information from a wide-spread knowledge base.

## **Chapter Three: ANALYSIS & DISCUSSION**

In this chapter I present the key discursive themes and historical contingencies identified within the analysis of the professional discourse of CP between the years 2010-2014. The first section represents the answer to the second research question. 'Alternative' and 'Leadership' are presented as the two main discursive themes identified in this analysis. Within each of those further associated discursive sub-themes are presented and analysed. The second section represents the answer to the study third research question and it presents 'Paradigm shift' and 'Any willing provider' as two historical contingencies that have influenced the profession of CP in recent years.

The discursive themes and historical contingencies are also discussed and the answer for the first research question is developed throughout the chapter through the exploration of the relationship between them.

### **1. DOMINANT DISCOURSES OF THE PRESENT TIME**

#### **1.1. Alternative**

The first discursive theme identified by this analysis was the CP as an alternative clinical practice. This discursive theme is presented repeatedly by the profession of CP to differentiate itself from all the other non-CP practices. The word 'alternative' was chosen here to represent the discursive strategy of division and specialisation that will be demonstrated in this section.

This alternative discourse of CP is not to be confused by the alternative approaches to CP mentioned in Chapter One, section 3.3. Within the profession there is a wide diversity of practices, some are considered mainstream and others are considered alternative, such as critical and community approaches. This is indeed an important point of tension within CP that is neutralised by this generic discourse that the whole profession is considered alternative and I will return to this discussion below. The analysis of the sub-themes supporting the 'CP as an alternative practice' discourse

in this section will demonstrate that there is more diversity and contradictory elements within this supposedly unified discourse.

CP as an alternative model of care is a dominant discourse within the profession as shown in E1, E2 and E3.

[E1] <sup>2</sup>Clinical psychology offers an alternative to other models in health care, such as the medical, psychiatric, forensic, moral and sociological. The rapid development of the profession out of an initial quasi-medical focus on psychiatry and child guidance has led to clinical psychologists progressively becoming able to identify their unique competencies and interventions, which call upon scientific as well as ethical practices. (Beinart, Kennedy, & Llewelyn, 2008, p. xiii)

[E2] When I did my BPS management training I was told, well that was a while ago, I was told that psychologists were regarded as like the creative part within a business model part of the research and also part of the advertising, that they were an engine of change and innovation, and I must admit I tend to think about psychology service that I'm involved with very much as doing that and so not wanting to get ourselves too trapped by, yes evidence based information is important but actually also we're the ideas factory if you want something new if you want some new energy come to us. (DCP Colloquium June 2011 – Jennifer Clegg)

[E3] In many NHS Trusts and Boards and in independent and third sector practices, clinical and applied psychology will continue to thrive and provide great and much needed and life changing services. We will continue to be a significant force for

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<sup>2</sup> The numeration of the quotes used in this chapter merely reflects the order in which they are presented through the text to facilitate sign-posting.



change, innovation, and evidence and outcome-driven care.(Pemberton, 2014)

'Engine of change and innovation', 'ideas factory', 'life changing services' and 'scientific and ethical practices' are some of the constructs within the alternative discursive them of CP. Constructing the profession as this creative, efficacious, fundamental and trustworthy alternative practice attributes certain qualities to CP practice that differentiates the profession from the others. Through this dichotomisation the 'medical, psychiatric, forensic, moral and sociological' approaches, usually encountered in the services in which CP work, are constructed as oppositional and different, implying that they may be non-scientific, unethical, and unable to be creative and innovative. CP is currently constructed by the profession as an alternative practice in relation to any other non-CP approaches to care, as E1 describes.

This alternative and unique discourse within CP is not new; it was indeed a 'selling point' of CP in the MAS review in 1989. However, using genealogy and going back through the historical trajectory of this discourse, the idea of CP as an alternative form of intervention has been around since the mid 1940s, when post war conditions were right for a psychological practice within mental health to gain some power and to be strategically combined with the dominant bio-medical view reigning at that time (Pilgrim & Treacher, 1992). There is a consensus amongst historians of the profession that CP started within the NHS and quickly became an accessory and subordinated profession to psychiatry, responsible for psychological assessments which consisted at the time mostly of psychometric assessments and psychological testing (Hall et al., 2002; Hall, 2007a; Hall, 2007b; Miller, 1996; Newnes, 2014; Pilgrim & Treacher, 1992; Rose, 1985).

Furthermore, after the Second World War the CP role in the UK was organised formally alongside the creation of the NHS, mostly by educational psychologists working with children and families in the Child Guidance Clinics (Hall, 2007a; 2007b)., Cromby *et al* (2013), Hall (2007a; 2007b) and Pilgrim and Treacher (1992) described how the dominance of psychiatry was maintained within adult mental health when the asylum system was assimilated by the NHS in 1948. The

legitimisation of the psychiatry profession in the leadership of mental health services had already been supported by reform to the legal system with the Mental Treatment Act of 1930 that attributed legal responsibility to the medical professional even prior to the creation of the NHS (Cromby et al., 2013; Pilgrim & Treacher, 1992). The pioneer professional psychologists within the NHS initially had to negotiate with psychiatrists to have direct access to intervene with adults within the mental health system (Hall 2007a; 2007b). While initially a very small profession they worked to expand their range of activities and distance themselves from the connection with psychiatry (Miller, 1996).

Nevertheless, from an initial position of subordination, over the years the CP profession managed to be strategic in relation to the dominance of psychiatry, evolving from a complacent beginning to a more eclectic and challenging professional practice that, by the 1970s, stood in radical opposition to psychiatry (Pilgrim & Treacher, 1992). However, it was only with the introduction of behaviour therapy in the 1960s that CP included the delivery of psychological therapies within its role in the clinic that created the conditions in practice to implement the alternative discourse as it stands today (Newnes, 2014; Pilgrim & Treacher, 1992).

Returning to the analysis of the alternative discursive theme, E4 does explain in more detail what is the alternative and unique model of CP, including the required professional skills:

[E4] Clinical psychology is one of the applications of psychological science to help address human problems. Clinical psychologists have been trained not only to be critical consumers of research, and ever emerging knowledge bases, but to contribute to this knowledge base through research, with relevant skills benchmarked at doctoral level. Clinical psychology has a prominent history of developing, evaluating and refining psychological interventions which are often then promulgated across the skill base of other professions and practitioners.

Complementing this capacity to draw critically from the evidence base to inform their work, clinical psychologists embrace an ethos of practice based evidence. A critical evaluative stance pervades practice which includes utilising an outcomes framework, informed by well-being and recovery principles, as well as the values and goals of the service user. Clinical Psychologists will often lead on developing systems of practice based evidence within services.

Reflective practice is also promoted through an effective use of supervision and collaboration with service users and other colleagues in setting goals and monitoring progress.

Importantly, the clinical psychologist will also be aware of the importance of diversity, the social and cultural context of their work, working within an ethical framework, and the need for continuing professional and personal development. (Committee on Training in Clinical Psychology, 2013)

The extract above reveals another discursive theme used in the construction of the alternative discourse: clinical psychologists as applied scientists. It refers to the profession's core identity of applied scientist and affirms the quality of its research skills because they are 'benchmarked at the doctoral level'. Other analytical skills have been described within descriptions of CP: 'reflective practice' (E4), 'practice based evidence' (E4) and 'clinical judgment' (E6 below). Although those practices bring something new and different from the traditional scientist-practitioner model, it has already been argued by previous historical analyses of the profession that they also serve to mystify part of the professionals' skills (Cheshire & Pilgrim, 2004; Pilgrim & Treacher, 1992).

Considering Rogers and Pilgrim (2010) characteristics of a profession enunciated in Chapter One, section 2.1, professionals' skills turned into a benchmark imply that they are of a superior quality to the skills of other practitioners which is an essential strategy professions use to keep themselves important, valued and relevant, in particular if others could provide similar services. If this benchmark is associated

with prolonged training and a qualification such as that of a doctor the professional credibility is increased.

In the following section, I will analyse separately the discursive sub-theme of applied science within CP and will return to the discussion of the doctoral title of CP. Here it suffices to say that because of the nature of the training in CP, some of these unique professional skills are only acquired from within the practice, 'on the job', which keeps them exclusive to the selected group who practice them, or those who are able to enter the doctorate in clinical psychology. Newnes (2014) described that presently, because of the competitiveness in entering the doctorate training, a lot of the successful candidates already hold a post graduation degree, such as a master or a PhD, indicating that the benchmark level is being pushed even higher.

Using archaeology to analyse the alternative discursive theme indicates that higher academic credentials and their association with scientific status is a way of organising this discursive theme. British CP is constructed as a unified and homogeneous professional practice, ignoring the actual differences between the ethos of the training institutions, as mentioned in Chapter One, section 3.1, and the different and conflicting opinions of clinical psychologists about what is science. How clinical psychologists understand in practice their application of science will be analysed in the following section.

#### 1.1.1. Applied scientist

In this section I explore the use of the 'applied scientist' discursive sub-theme. Applied scientist is not a discourse exclusive of CP, other professions are conceptualised similarly, for example medicine can be understood as the practical application of Biology and engineering as the practical application of Physics. In terms of CP, this discourse is used in a broad sense encapsulating the application of scientific principles, theories and findings of the Psychology discipline within the day-to-day clinical practice. Using the principles of organisation of the discourse, genealogy and archaeology set by Foucault in Chapter Two, here I explore how the applied –scientist discourse is portrayed as unified and definite although the analysis

of how clinical psychologists use this sub-theme reveals complexity, variation and ontological conflict.

The application of the science discourse is still used today as a unique selling point of the profession, indeed one at the core of the uniqueness, as indicated in E5.

[E5] The appliance of science', the reason why I've gone for that title that will become clear as we go through, and I think that's our unique selling point. [inaudible] what we're about, what's different. (DCP Colloquium June 2011, Jenny Clegg)

The extracts below, selected from a textbook used to educate clinical psychologists (E6) and from the DCP (2001) document *The Core Purpose and Philosophy of the Profession* (E7), have definitions of the professional practice of CP which use the applied scientist discourse. From a Foucauldian perspective, the discourse presented by these official sources, with their authority on the subject matter defined by their authorship, represent the realisation of the alternative discourse.

[E6] The profession of clinical psychology involves using clinical judgement to apply knowledge from the scientific discipline of clinical psychology in clinical practice with clients and patients. Clinical practice refers to the assessment, treatment and prevention of psychological problems in a range of populations. (Carr, 2012, p. 2)

[E7] Clinical psychologists as scientist-practitioners  
Clinical psychologists are more than psychological therapists. While many do practise psychotherapy at a high level this is not a skill unique to clinical psychologists, nor should it be. The background and training of clinical psychologists is rooted in the science of psychology, and clinical psychology may be seen as one of the applications of psychological science to help solve human problems.

The ability to design and carry out applied research is a skill developed to a doctoral level in training and is one that is becoming

more and more valuable in the drive towards evidence-based practice. In addition, one element of research competence is critical evaluation of research activity and this again is a skill which will be increasingly in demand over the coming years.

[...] It is important to emphasise that this research activity is not thought of as an activity removed from the “real” clinical workplace. While there are good data which support many clinical activities, there are still major gaps in the knowledge base. One of the important ways in which clinical psychologists contribute is in the development and testing of new interventions and activities, based on psychological theory. Thus practice feeds and draws on research and theory which in turn influences practice. (Division of Clinical Psychology, 2001, p. 4)

The discourse of science is complex and its discussion goes beyond the discipline of Psychology and CP, and has been extensively explored elsewhere (e.g. Foucault, 1972; Rose, 1985). Constructing the applied scientist discourse based on applying the ‘science of psychology’ in the way described above by all the quotes does not do justice to the broad, varied, conflicted and contradictory aspects of ‘psychological science’. One possible historical explanation for this is that the professionalization process of CP in the UK, as Hall (2007a) described, was unique because of its simultaneous development within the NHS. From the beginning the NHS was set up to deliver health services based on scientific knowledge and CP was put into the ‘Professional & Technical A’ (PTA) staff grouping early on, via the Whitley Council System, which ensured the scientific role of this non-medical professional group (Hall 2007a). I will continue the elaboration of this argument in section 2.2 at the end of the chapter, when I discuss the present situation of the profession within the changes to the NHS commissioning system and how it impacts on the way CP positions itself.

An archaeological analysis of the data set revealed that within CP, the science discourse is very complex corresponding to a wide range of practices and at times passionate disagreement amongst the professionals. Clinical psychologists use a

variety of techniques under the applied scientist identity, for example, E8 mentions how this unique selling point is put to use by interpreting data from the guidelines and E9 uses the applied science to develop something new.

[E8] [I]f we are applied psychologists than our [inaudible] knowledge base is psychology and our starting point does need to be looking at what's been done already, what seems to make a difference, but what's special about us, I do think, as applied scientists is that we are able to, in a more meaningful way, actually look at what science [inaudible] being presented to you, and actually make some, hopefully sensible, intelligent decisions about what that actually means in terms of the [inaudible] and that's why I suppose I'm very keen that we do take a leadership role because I think we are in a position where we can interpret, in a far more meaningful way, the sorts of data that comes out of [NICE and elsewhere?] and I don't think a lot of the time [inaudible] commissioners can, so it's leadership in understanding and interpreting the science rather than a sort of straightforward it says this and therefore we ...(...) (DCP Colloquium June 2011, Jenny Taylor)

[E9] I would say we as applied scientists uniquely provide which is the opportunity of a scientifically tailored approach to their problem in the absence of a specific therapy that matches their specific problem when people are lucky to have [inaudible] or unlucky enough to [inaudible] Of course there are some broad areas where we do think broadly speaking the sorts of presentations is helped by this sort of intervention and I certainly think that is the case there are some areas like that, there are all sorts of types of difficulties, combinations of difficulties that don't by any means fit into those sorts of boxes and that's when we need something a bit more complex [inaudible] (DCP Colloquium June 2011 – Jenny Taylor)

Nowadays CP discourses use definitions of science-practitioners to emphasize the scientist skills of clinical psychologists: 'more than psychological therapists' (E7), 'there are still major gaps in the knowledge base' (E7), 'development and testing of new interventions and activities' (E7), 'interpreting the science' (E8) and 'scientifically tailored approach to their problem in the absence of a specific therapy' (E9). These extracts are evidence of the continued struggle between scientist and therapist roles.

Using genealogy to investigate the trajectory of the conflict between the discourses of applied science and therapy I identified that British CP had established itself from the beginning as a purely scientific endeavour in which treatment and therapy were not part of the clinical practice (Eysenck, 1949). This reflected an opposition to psychoanalysis, the main talking therapy available at the time. Applied science covered the development of assessment tools and psychometrics tests; treatment in the clinic was left to psychiatrists (Cromby et al., 2013; Hall 2007a; 2007b; Hearnshaw, 1964; Newnes, 2014; Rose, 1982; Pilgrim & Treacher, 1992). The incorporation of therapy within the role of clinical psychologists in Britain would only take place because of the development of Experimental Psychology and Behaviourism in the 1950s. Tension between the different theoretical orientations of the original training centres of clinical psychologists, the Maudsley Hospital and the Tavistock Clinic in London and in a relatively less influential way the Crichton Royal Hospital at Dumfries, were also part of the context in which these negotiations took place (Hall, 2007a; Pilgrim & Treacher, 1992). Before this the only available form of therapeutic intervention had a psychoanalytic base and its epistemology could not be consistent with the scientific basis of CP according to Eysenck (1949). As Hall (2007a; 2007b) has demonstrated, Eysenck had in fact little influence in the negotiation processes of the profession of CP within the NHS, however he represented the academic side of clinical psychology in his position of course director at the Maudsley. Nevertheless Pilgrim and Treacher (1992) identified that the majority of course directors of the different training centres that were created in the following years had originally trained at the Maudsley and they argued that this has been a major influence on the understanding of how the scientist-practitioners identity was developed in the UK.



Interestingly the present conflict between the applied scientist and therapist discourses reveals the complete reversal of the original issue that composed the concept of scientist-practitioner in the 1950s that was the inclusion of the role of therapist into a scientifically dominant practice. The struggle these days seems to be the opposite: to move away from the therapist identity and to valorise the applied scientist skill of the profession. The identification within the professional discourse of the inverted polarity of the power dispute between therapist and applied scientist skills would represent in practice a move from a MAS level 2 skills set to those of MAS level 3.

However, as I have already identified in Chapter One, sections 1.2 and 3.1, this does not seem to be the case. Recently the therapist role within British CP has received more political and public attention. This puzzling difference between the discourse and the current practice reveals the depth of this identity conflict within CP and the importance for the identification of further discursive themes and historical contingencies which are influencing this conflict. The analysis of the therapy discursive sub-theme and its recent socio-historical construction in section 1.2.3, will clarify the question of the power balance within the tension between the applied scientist and therapy discourses.

I will see below how other societal and professional discourses contribute to the picture of a profession which is still in conflict, on one hand valuing its unique skills but on the other hand valuing the expansion of its professional domain, and will expand this discussion. As further discursive themes and sub-themes of CP are discussed in the remainder of this chapter this point will be revisited and I will argue at the end of the chapter that it is the combination of an increasingly competitive therapist market within the NHS and the present days dominance of the Positivist discourse of science that seems to draw the profession to align itself with, and defend, its specialised niche even if at the cost of limiting its scope to deliver non-CBT and non-therapy interventions.

To finalise the discussion of the subtheme of applied scientist it is important to return to the questions which remain to this day about the actual impact of the scientist and researcher role of CP as mentioned in Chapter One, section 2.3.3. A series of

studies identified that little scientific contribution is made by the majority of clinical psychologists in the UK (Eke et al., 2012; Norcross et al., 1992a; Norcross et al., 1992b). Pilgrim and Treacher (1992) had hypothesised that the scientist-practitioner discourse of the profession is more rhetorical than factual, and is used as a professional strategy to differentiate and valorise CP versus other professional of the MDT. Newnes (2014) reiterates these findings affirming that current clinical psychologists do not produce as much research as the professional discourse claims that they do.

## **1.2. Leadership**

The discursive theme of leadership has been identified as a second dominant discourse of the current profession. In fact, it could also be said that the leadership discourse is a strategic way to implement the alternative discourse as combined they strengthen each other's power. The leadership discursive theme of CP refers to the profession's ability to organise and govern other professionals within the mental health field because of the claims of having high quality scientific skills. In this section the current organisation of the leadership discourse will be analysed and discussed and its repeated use of doctorate level training and numeric presence as supporting arguments. I will also analyse how the leadership discourse has been influenced by the recent socio-historical context, in particular the IAPT initiative. This section will also analyse three associated sub-themes identified as part of this dynamic construction: well-being, Cognitivism and therapy.

The analysis of the data set identified that the high quality of clinical psychologists' professional skills is recurrently used to justify the leadership discursive theme. The quotes below reflect the recent context of greater public concern caused by recent NHS changes (E10) and recent scandals of abuse and neglect within the health and social care services (E11) and quality of care has been under the spotlight. The analysis of the alternative discursive theme, as seen above in section 1.2, had already indicated that a discourse about high quality is used and is favourable to the profession of CP.

[E10] Of course, we strongly argue for continued investment in evidence-based psychological therapies, and particularly for preventative work. We fear the consequences of poorly-informed commissioning decisions in these areas. Equally, commissioning decisions in respect to psychosocial interventions depend very heavily on the properly-qualified, robustly-regulated, professionals to deliver them.

Psychological interventions are effective and very popular.  
(Kinderman, 2011c)

[E11] Improving access to psychological therapies will continue to be supported by all the main political parties. Winterbourne and Mid Staffs have concentrated the minds of commissioners, managers and politicians on the quality of services, not just their cost. It is important that we exploit these agendas in the interests of delivering new patterns of service and better care.  
(Pemberton, 2014)

‘Properly-qualified, robustly-regulated’ (E10), ‘effective and very popular’ (E10), ‘quality of services, not just their cost’ (E11) demonstrate how effectiveness and high quality psychological services are key discourses that support CP’s claims to leadership positions. The connection between effectiveness and high quality psychological services are also indicative of the practice that CP constructs within these discourses, led by the positivist claims of evidence-based practice. The Clinical Governance drive, started by the DH in 1998, and the establishment of the NICE guidelines in 1999, , ensured that evidence-based practice became the norm within the NHS (Cheshire & Pilgrim, 2004). Evidence-based practice as seen above (E7) aligns itself well with CP’s applied scientist discourse.

Using genealogy to analyse the trajectory of the discursive theme of leadership and evidence base within CP, we are reminded of the historical development of the NHS as a scientific project which started with the neo-liberal governments at the end of the 1970s (Pilgrim & Treacher, 1992) and was consolidated further in the 1980s and 1990s. Indeed it was the need to specially consider and scrutinize the profession to fit this scientific project that led to the 1977 Trethowan Report. The Trethowan report (1977) attributed to the scientist-practitioner approach the great ability of clinical psychologists to contribute to the overall scientific-project of the NHS because of their research skills and ability to draw from a broad range of theories to apply to a variety of services of mental and physical health, across the life span.

The Trethowan report (1977) and the MAS review (1989) had already described CP as a profession that applied scientific principles to everyday practice in a variety of contexts, to all age groups and diverse sorts of difficulties. Reconsidering this study's first research question, the leadership discursive theme is consistent with clinical psychologists working at a MAS level 3 in terms of the professional's ability to provide consultancy, indirect interventions, training and supervision.

Making use of the recommendation of the Threthowan Report, CP entered a managerial phase in the 1980s as argued by Pilgrim and Treacher (1982) and secured a place in the provision of management, supervision and training to other professionals providing psychological therapies. In the 1990s, the leadership discourse became more instrumental as a response to different waves of service changes and other wider discourses, such as New Labour's clinical governance drive (Cheshire and Pilgrim, 2004). This added the administrative dimension as a requirement to the provision of higher quality of clinical services, and delegated the organisation of the services to the relevant professionals and managers.

The combination of the Clinical Governance discourse and the administrative changes of both Agenda for Change and National Skills Framework gave further power to CP's discourse of leadership, always justified by the high level of training. It was in the 1990s that the qualification required for by CP was upgraded from a master to the current doctorate. These days, CP discourse about the doctoral level is strategically used to argue for CP to be put in leadership positions so as to justify the investment in a comparatively more expensive professional.

Returning to the analysis of the leadership discursive theme and using some archaeology, the academic level of training was frequently used in its construction. As seen in section 1.1, above, the doctorate is directly associated with the delivery of scientifically based services within the CP discourse (E4). Within the evidence-based discourse, CP has the knowledge claims to be put in leadership positions as E12 because of the doctorate.

[E12] (...) because 5 years from now we would want I think a structure something like this where the cohort of 650 clinical psychologists being trained every year and health psychologists, forensic psychologists and so forth we'd expect those doctoral level people to slide up that side of the pyramid to be in senior positions after a reasonable amount of time but when you cut across what a Trust should be commissioning is probably a portfolio of staff which is not predominantly clinical psychologist or psychiatrists it's actually predominantly is relatively lesser trained people in other professions so be very cautious about what we're interpreting from it. (DCP Colloquium June 2011 – Peter Kinderman)

The current socio-economic and political scenario, and the convergence of the discourses of quality and science, helped CP to establish itself in a superior position in relation to the other providers of talking therapies (Cheshire & Pilgrim, A short introduction to Clinical Psychology, 2004). As I will discuss at the end of this section, the discourse of leadership based on Clinical Governance claims was reiterated by IAPT. However it is necessary for us to analyse the numeric argument, repeatedly found within the data set, as seen in E13, that is both used to justify the leadership discursive theme and that has been strategically used by the profession to realise its leadership claims within the IAPT project.

[E13] Across the UK, there are now about 10,000 clinical psychologists. 90% of us work in the NHS. We are, it's worth

pointing out, the only profession in the NHS for whom the base-line entry requirement is a doctoral qualification. (Kinderman, 2011c)

A calculation made in chapter one showed that in 2014 clinical psychologists represented more than 48% of the registered applied psychologists within the HCPC, making the profession the dominant one amongst applied psychologists. However, when considering numbers and dominance, it is worth taking into account the bigger picture. CP is only 0.74 % of the 1,146,065 non-medical NHS staff (NHS Institute for Innovation and Improvement, 2010). And although the total number of clinical psychologists has increased considerably over the years, when compared to the total numbers of people employed in the NHS it is still a very small profession.

A more meaningful alternative for the discussion here is to look at the size of the CP profession within the mental health services. For example, according to 2013 Census of the Royal College of Psychiatry, there were more than 4,500 consultant psychiatrists in post in the UK, and if I use the DCP information stated in Chapter One, section 3.1, that recognise that it has 9,500 members, which includes trainees and qualified members who are not consultant psychologists. A simple calculation reveals that the ratio between the professions is more than 2:1 clinical psychologists than consultant psychiatrists; from this perspective the discursive theme of CP as a small profession loses its credibility. However, I have already clarified that the socio-historical construction of the adult mental health services in the UK has privileged a psychiatric explanation of human distress since before the creation of the NHS and the existence of clinical psychology (Cromby et al., 2013; Pilgrim & Treacher, 1992).

E14 shows the numeric argument being used to justify putting CP in the leadership position to use its MAS level 3 skills: cascade its unique skills indirectly via supervision, training, teaching and consultation.

[E14] It is important to emphasise that clinical psychologists may have their greatest influence on enhancing psychological well-being of service users by working at systemic levels. There will always be more demand than psychologists can

fulfil, so by working with organisations to provide psychologically appropriate services, or by working in a staff development and supervision mode, clinical psychologists can ensure that many more users have access to psychologically informed practice than can be delivered by psychologists alone. (DCP, 2001, p. 5)

Looking at the historical trajectory of the discourse of the numeric proportion, the issue of CP being a small profession was one of the original drivers to commissioning the MAS Review (1989) and the MPAG Report (1990) and it is a continued justification in the history of the profession for the indirect work at MAS level 3. Nowadays CP's small numbers are still identified as a limiting factor to the implementation of CP's alternative discourse (see section 3.3 below. and quotes E36, E37 and E38 about the barriers to the profession's opinion to be considered in matters of policy).

CP taking the leadership role in psychological matters within services has always been a complex and relative issue, depending on the specificity of the service itself, as shown by E15.

[E15] Currently, clinical psychologists are probably in the best position to advise on the psychological needs of the communities they serve and on how such needs might be fulfilled. Because of their historic position in the NHS and their numbers (they are currently the largest single group of applied psychologists) they can advise on what sorts of psychologist are required to fulfil which psychological needs. This will include ensuring that different types of applied psychological skills are properly represented in the portfolio of services offered. This implies an organisational framework that allows for a variety of different skills and talents to be used. This can only happen properly if psychology services are organised in such a way as to employ a variety of different applied

psychologists and other professionals. (Division of Clinical Psychology, 2001, p. 7)

To summarise the analysis of the leadership discursive theme, its historical trajectory and how it connects to the 'CP as an alternative practice' discursive theme, section 1.2, has been socio-historically constructed and allows the profession to make claims to be put in leadership positions within MDT services because it has few professionals to apply its alternative and unique, scientific and high quality approach to human questions. At the end of this section the analysis of how the historical contingency of the creation and establishment of the IAPT initiative has put a different spin on the numeric discourse and challenges the core of the argument for the delivery of interventions beyond individual therapy, to answer the first research question.

The IAPT service model has expanded from its original design and no longer restricts itself to adults, now it has been rolled out to children and families services and there are pilots of IAPT services to people who experience psychosis (Department of Health, 2011). Critics have pointed out that Lord Layard has made 3.1 other proposals with the assistance of a team from the Institute of Psychiatry that could possibly foresee a 'cradle to grave' mental health policy (Pilgrim, 2013). The Institute has its own particular ethos (scientific and positivist) and has always been at the centre of CP professional development in Britain (Pilgrim & Treacher, 1992).

As already identified in Chapter One, sections 1.2 and 3.1 the IAPT service model has had an impact on the profession of CP, which has been criticised for aligning itself with the evidence-base, Cognitivism and therapy discourses. E16 speaks about the institutional and administrative impact IAPT has had in the profession as a whole:

[E16] I think we've got to accept that IAPT is a good thing; it used to be that we only used to treat people at the very tip of the iceberg, what IAPT has allowed to happen is the bigger part of that [inaudible] to be treated but it's a new population. And



the risk we're engaging with has actually revealed some of that slice that was below the water but actually stopped treating the tip of the iceberg. (...) There were services reporting that any vacant posts within psychology were being translated into IAPT posts so it was having a direct detrimental effect on staff in secondary services and there were a lot of people saying that their internal line managers and commissioners were saying: "This IAPT thing is great, why aren't all services like that? It's cheap and cost-effective, why do we need all these psychologists for?" [some inaudible comment about bands, maybe band 7]. And what all this is meaning is that potentially the more complex group missed out [inaudible]. (DCP Colloquium June 2011 – Mike Oldridge)

E16 exemplifies the impact that IAPT had on the profession. As discussed above, the IAPT model does contribute to assuring a place of leadership for CP and to promote psychological therapies. The Pilling and Roth stepped care model (2007) had secured CP's application of MAS level 3 to the more complex cases within the primary care set up. The BPS and DCP involvement in supporting IAPT had also secured CP's role in managing, co-ordinating, supervising and training within the service model.

Looking at the genealogy of the discourse of CP within primary care services, I identified that the promotion of psychological therapies in primary care was indeed a proposal of the MAS review (1989). The MAS review vision that having CP working in primary care would be strategically better and cost effective for the NHS in their aims of health prevention and promotion, based on the idea that: '(...) the "worried well" are tomorrow's more seriously and chronically mentally ill.' (Management Advisory Service, 1989, p. 7), might have been misleading. As E16 reports, it appear that the 'worried well' is an entirely different group to the complex and vulnerable service user groups that clinical psychologists have the professional skills to work with.

Another point clearly raised by E16 is the perceived migration of qualified clinical psychologist to work in primary care, as a consequence of IAPT, which has opened up the possibility for commissioners to think that clinical psychologists in senior positions are not needed. Contrasting this with the discursive theme of alternative from section 1.1 above, having fewer professionals in senior leadership positions, those who would enable the creative and unique alternative approach of CP to be practiced could potentially be detrimental to fulfilling the potential of the profession. The discussion of the IAPT model and how it is used within the discourse of CP will be continued in section 1.2.3 below.

### 1.2.1. Well-being

Well-being is a discursive sub-theme identified within the current professional discourse of CP. As we are going to see in this section the well-being discourse is used in wider circles beyond CP and one of its use within CP seem to be the convergence and alignment of State and professional discourses. Within CP this discourse is used to conceptualise an ideal state of human experience, which includes a possible explanation of distress. The data set has shown recurrent use of the well-being discursive sub-theme when professionals discuss the current fronts in which CP could take a leadership role as shown by E17.

[E17] So there is the wellbeing agenda which the government's shit hot on but interestingly although the NHS says that it's in favour of wellbeing as Labour said previously it seems to be places other the Department of Health that actually engage with wellbeing as an agenda which is interesting. And I think that it's important to say their contribution is also scientific, you can do that stuff, which I shall do later this week in Belfast, about we are the only doctoral entry profession in the NHS. But also that I think that science is much less controversial and less complicated than people make it out to be, what we basically say is that people's interactions with the world and therefore their behaviours and their mental [coughing] depend on their

framework of understanding of the world and people develop their frameworks of understanding of the world because of the learning experiences they've gone through in their lives. It's not a complicated message once you get it across and it's not really about dopamine and serotonin, it's about learning. So we've always had multi-dimensional formulation based approach, we've always applied science when we need to do. (DCP Colloquium June 2011- Peter Kinderman)

Expertise about well-being is another discursive themes identified as used by the profession to justify its knowledge claims within the field. Well-being is constructed as 'learning experiences' and not 'dopamine and serotonin', placing it within the domain of psychology and not psychiatry. And CP's knowledge of science, benchmarked by its doctorate level qualification aligns, as seen above in section 1.1 the profession with the government drive, even if not within the DH domain. This discourse of well-being within CP's domain is found recurrently at the centre of the present discussions about the profession as shown in E18 and E19.

[E18] Clinical psychologists are trained to reduce psychological distress and to enhance and promote psychological well-being by the systematic application of knowledge derived from psychological theory and research. Interventions aim to promote autonomy and well-being, minimise exclusion and inequalities and enable service users to engage in meaningful interpersonal relationships and commonly valued social activities such as education, work and leisure. (Committee on Training in Clinical Psychology, 2013, p. 5)

[E19] (...) it's worth pointing out for the ears of politicians, that a focus on well-being means improving the well-being of the whole nation through greater employability, productivity and social inclusion.

For us as psychologists this means an equivalent focus on maintaining and maximising personal well-being... not merely treating supposed illness, but developing healthy functioning humans. And our well-being, in turn, is complex...

#### DOMAINS of WELL-BEING

Well-being, what's important to us as human beings, covers a wide variety of issues – social relationships (social, parental, loving), mental health, physical health, physical security – freedom from crime and the fear of crime – housing, education, employment, sports and leisure, arts and culture, and spirituality...

They also include – and these are challenges for psychologists as well as politicians – the importance both of a sense of 'meaning and purpose' and democratic political participation. ... although I recognise how stunningly difficult it is to increase a person's sense of meaning and purpose, and I also realise the political delicacy of discussing democratic participation (...) (Kinderman, 2011c)

[E20] One of the messages that I give is an interesting message because it's about well-being and saying that we have social psychologists interested in, well in the area of intervention; we have educational psychologists, forensic psychologists, clinical and counselling psychologists, we have sports and active science psychologists, we have occupational psychologists, all of whom are working to improve well-being but that's still in the context of what we're discussing, a slightly reactive model, which is to say we don't only diagnose and treat mental illness, we've got a number of other professions as well and they really should be taking a much more umbrella, a much more "psychology is the science of how human beings work in their relationships with others" and then it follows a sort of top down message. (DCP Colloquium June 2011- Peter Kinderman)

The professional discourse of CP claims expert knowledge over matters of well-being. The well-being discourse has been used as a strategy to distance the practice of CP from the 'problem' and 'disorder' discourses. The BPS Professional Board published a document in 2009 proposing that a well-being approach should be adopted as a 'new ethos for mental health' (Kinderman & Tai, 2009). Although this model supports a multi-professional approach and takes a health prevention and promotion stance, including the possibility of community level interventions, it emphasises that the ability of applied psychologists is to develop scientifically informed formulation of the individuals' difficulties (Kinderman & Tai, 2009).

Although this model is constructed as inclusive and contextualised, there are a lot of elements of individual responsibility implied by the description of well-being and although broader socio-economic and cultural issues are set outside the clinical psychologists' domain, in the hands of politicians, some of the domains left to psychologists can be understood as not merely down to an individual's choices. A lot of the areas of life singled out as important such as 'freedom from crime and the fear of crime' (E19), 'housing, education, employment, sports and leisure, arts and culture, and spirituality' (E19) construct as the object of CP professional practice issues broader than the individual, which to be addressed would require clinical psychologists working at a MAS level 3, indirectly working with individuals, families, groups and communities towards these societal goals.

Issues of 'meaningful interpersonal relationships' (E18), 'social relationships (social, parental, loving)' (E19) are constructed as if reliant solely on the person's abilities, which is at odds with a lot of service users' realities. Accordingly to Pilgrim and Treacher 'The framing of social relations as individual characteristics is probably the most important occupational hazard of applied psychology' (1992, p. 180). The well-being discourse used by CP appears to serve the function of keeping the focus of CP on individuals' needs, even if in a different format than that of treatment of specific problems. The issues of the 'problem' and 'disorder' discourse within the profession will be discussed further in section 3.3.1 below.

The key potential of the well-being approach advocated by CP is its convergence with the current interests of the State. As seen in Chapter One, sections 1 and 1.2, currently politicians do have an interest in well-being and in positive psychology theories. Some of the domains of well-being described in E18 and E19 exemplify how well-being is narrowly constructed around individual characteristics and achievements valorised by a Westernised, post-industrial and capitalist society, such as 'education, work and leisure' (E18). As Cederstrom and Spicer (2015) put it there is a political expectation that: 'wellbeing will produce more responsible and hard-working people, running on all cylinders, and only rarely in need of medical care' (p. 76), the 'healthy functioning human' (E18) constructed by the well-being discourse and endorsed by the applied scientist clinical psychologist.

If the object of the practice of CP is to produce 'healthy functioning humans' then the subject that the professional practice constructs with this discourse denies the expression of difficulties and the existence of conditions exterior to that individual which may cause him to be unhealthy or dysfunctional as evidenced by The Marmot Review (2010), WHO (2009) and Wilkinson and Pickett (2010). This is indeed a very serious point of contention among clinical psychologists that is obscured by the apparently unified professional discourse of science, which has been analysed and discussed above in section 1.1.1. As seen in Chapter One, critical approaches to CP believe that it is indeed the suffering of distress and the systemic complexity of the environment, the society, in which human beings live, that forms part of the condition of being human as argued by several authors within *Medicalisation of Misery* (Rapley, Moncrieff & Dylon 2011).

In spite of this overwhelming evidence from critical psychology approaches, it is the well-being discourse that is used to align CP professional discourse with the greater political power. Although the well-being discourse emerged within the previous Labour government the current government also initially endorsed it to the extent of using the concept as an outcome measure, as described in Chapter One, section 1, more recently it has showed more caution and contrasted the level of evidence of the well-being model in relation to the traditional mental illness model (Department of Health, 2013). Nevertheless this alliance of professional and political discourses results in the strengthening of the power of all the discourses of the profession of CP

and has opened up possibilities of expansion for the professional practice in recent years. Formulating well-being as a combination of distinct domains, even if considering some socio-economic and cultural aspects, offers a good match with the scientist-practitioner discourse ethos and opens up the possibility for CP to legitimately claim to have the expertise in areas beyond mental and physical health settings therefore continuing the expansion of its professional territory as shown in E19.

Analysing the history of CP's discourses and their trajectory, it is interesting to see now the use of a discourse that creates the possibilities for CP to move back to areas of work, such as industry, school and social security, in which the undifferentiated applied psychologists started (Pilgrim & Treacher, 1992; Rose, 1985). The experience of the World Wars in Britain opened up, and gave a power to applied psychology in new areas of work outside the hospital and the asylums: the expansion of the application of psychological techniques to improve efficiency in factories, support of shell-shocked soldiers and to aid military recruitment. According to Miller (1996) 'indigenous factors' of the profession go back to the management of the shell shocked soldiers of the First World War and its application in the military field. British applied psychologies subsequently developed within the industrial sector between the wars and during the Second World War with the work in military hospitals and in personnel and selection (Miller, 1996). This influenced not only the development of CP but also the field of organizational psychology and their separation.

The challenge posed to the professional practice of CP by 'sense of 'meaning and purpose' and democratic political participation' (E19) leads to a recognition of the limitation of its mainstream practices. This point of recognition of the limited scope of the current practices of CP could be understood using Foucault's concepts of formation of discourses that an opportunity was opened up for the less dominant practices to be explored by the profession. In this context it could be an opportunity for Critical and Community Psychology approaches, briefly described in Chapter One, section 3.3 that provide an understanding of the individual's experience as integrally political to gain power. However, the processes by which discourses are organised and ordered close down this possibility by making use of other dominant

discourses. In the next section I analyse how the discursive sub-theme of Cognitivism is organised within the discourse of CP to maintain the dominance of the professional practice over matters of well-being.

### 1.2.2. Cognitivism

The Cognitivism discursive sub-theme has been found recurrently in use to support the other discursive themes used by the profession of CP currently in the UK. This discursive theme refers to the adoption of the theories and research findings of Cognitive Psychology into clinical practice. It includes the therapeutic intervention Cognitive Behaviour Therapy that operationalised the scientific knowledge in the day-to-day intervention of CP. In this section I present the analysis of how the discourse of Cognitivism and the practice of CBT align themselves with other macro societal discourses to become a dominant form of practice in the current British context.

E21 below shows how some of the discursive themes used within CP operate in the present. In the previous section the analysis revealed that possibilities were opened up for alternative and non-therapy practices by the well-being discourse. E21 shows how the possibility for the application of non-individualistic models of care, implying the application of MAS level 3 skills, are closed by the alliances of already dominant discourses of individual intervention through the provision of CBT. ∴

[E21] Of course, clinical psychologists intervene. We apply psychological science to improve individual – and national – wellbeing. (...) Psychology has very few laws (...) Stephens' Power Law (...) Thorndike's Law of Effect (...) But I believe it's now possible to enunciate two new laws reflecting what's been called the cognitive revolution.

#### TWO LAWS

1. Our thoughts, emotions and our behaviour (and therefore, of course, our mental health) are largely determined by how we



make sense of and understand the world, primarily our social world.

2. How we make sense of and understand the world is largely determined by our experiences and upbringing. (...)

Across the UK, the IAPT programme and the Bamford review are attempting to offer CBT and other evidence-based psychological therapies on a massively increased scale. (...)

CBT is a form of structured, guided, re-learning. People's mental health is determined by their mental model of their world (law #1) ... therefore if we can alter their mental model, consequently, their moods and behaviours change.

And... People's mental models are largely determined by our experiences and upbringing (law #2)... therefore if we can offer new learning experiences... (Kinderman, 2011c)

In E21 the discourses are articulated to construct the conclusion that the provision of CBT is the best option to improve well-being. The use of 'laws' to approximate the knowledge claims of psychology with the physical sciences makes overtly positivist claims and also invalidates the knowledge within psychology that is not postulated as scientific laws. The 'cognitive revolution' and its cognitive theories appraised as unquestionable and universal 'scientific laws', portrays them as the best alternative to address well-being. This uncritical use of the cognitive theories aids the construction of the scientist-practitioner professional (Pilgrim, 2009). This discourse of CBT theory as law, combined with the fact that services such as IAPT have been able to deliver this intervention to the public on a mass scale free of charge within the NHS (E21) supports the argument for this kind of therapy to become dominant in the current market, subjugating others.

[E22] NICE guidance increasingly highlights the need to tailor a range of psychological interventions to complex presentations and the specifics of service user contexts. A defining feature of the clinical psychologist is the capacity to draw from, and utilise, different models of therapy, and evidence based interventions, as appropriate to the needs and choices of the

service user. The clinical psychologist is not a uni-modal therapist, although by the end of training specific competencies will be professionally accredited, and statutorily approved, within cognitive-behaviour therapy (and one other model of therapy, which will vary, depending on the training pathway pursued). Many will develop further particular expertise in specific therapies. (Committee on Training in Clinical Psychology, 2013, p. 6)

Using genealogy I contextualise the controversy of the construction of CBT as unquestionably scientific and its encompassing application within CP domain. In Chapter One, section 3.1, I had already described how within the profession the turn to CBT is controversial and is still understood by many as a serious and risky position for the profession that places serious limitations on practice, as exemplified by the debate encountered within the special edition of the Clinical Psychology Forum in January 2011: 'Is clinical psychology getting lost?'

During the implementation of IAPT services in 2004 the connection between CP and CBT had to be legitimized by the profession and since the recent changes within the NHS commissioning system, there seems to be a further need to affirm the CBT skills of clinical psychologists. Although not all clinical psychologists in the UK are working within the IAPT model, this service model is frequently mentioned within debates and discussion about the profession as seen in E21, E22, E16, above, to affirm the place of CP within this drive.

The archaeological analyses of the discursive themes of CP in E21, above in this section, and E23, in the following section 1.2.3, show that the way that the dominance of the discourse of the superiority of CBT is organised is very often based on the dimension of the IAPT service rather than on knowledge about its effectiveness as a therapeutic modality. The power of the Cognitivism discursive theme is provided by the fact that IAPT has been already implemented on a massive scale, rather than in the actual demonstration that CBT is more effective than other types of psychotherapy (Llewelyn, Beinart, & Kennedy, 2008). The analysis of the organisation of the Cognitivism discourse within CP identified a cyclical dependency

that has been created by using NICE guidelines uncritically to support the establishment of a service and the use the outcomes of the same service to justify the legitimacy of the intervention. The circularity of this argument in which discourses rely on each other for their organisation has obscured the limitations of the CBT intervention.

### 1.2.3. Therapy

The practice of therapy has been identified as a discursive sub-theme that was frequently found within the data set. The analysis of clinical psychologists as applied scientists at the beginning of this chapter, in section 1.1.1, had already identified, that the use of therapy as a discursive theme within CP is not free from conflict and ambiguity. The genealogy in section 1.1.1 indicated that the professional discourse nowadays places value on the broad nature of the applied scientist's professional skills and tries at times to distance itself from the focus of delivering therapy. However, the analysis of the discourse of therapy in relationship to the discourse of leadership has identified that these two discursive themes are recurrently re-aligned when considering the impact of the IAPT services within the profession of CP. In this section I discuss how the recent consolidation of the discourse of clinical psychologists as experts in the delivery of CBT has re-approximated, if not reduced, the science of CP to the training, management, supervision and delivery of this specific form of therapy.

In the last few years the professional clinical psychologist has been constructed as a specialist in CBT and now it is officially stated by the HCPC regulation 2.b.4. (Health & Care Professional Council, 2014). One of the profession's leaders, the DCP chair Professor Peter Kinderman, makes use of this to justify CP's leadership role within the area of delivering CBT and other evidence-based therapies as proposed by NICE, and shown in E22 above, E23 and E24 below:

[E23] Across the UK, the IAPT programme and the Bamford review are attempting to offer CBT and other evidence-based

psychological therapies on a massively increased scale. That's excellent... even wonderful.

But... As we roll out psychological therapies, the quality of the service, the ethos of the service, the grounding in genuine psychological science – as I've outlined above – and, crucially, the competencies of practitioners must be maintained. We're all in favour of broadening the practitioner base... but sensibly, and retaining the application of genuine science. (Kinderman, 2011c)

[E24] As the NHS is being reformed under our feet, many members have commented that it is necessary to affirm, confidently and publicly, the distinct competencies and 'added value' of clinical psychology. One important area is the delivery of psychological therapy. This is clearly vital for our profession in the era of GP-led commissioning of mental health services. So I would like to offer a statement, in my role as Chair of the British Psychological Society Division of Clinical Psychology about the distinctive contribution of clinical psychology. Clinical psychologists are experts in the design, delivery and supervision of evidence-based psychological therapies, including, of course, CBT. Our skills extend well beyond this, and psychologists place such evidence-based psychological therapies within psychological formulations which draw on a broad range of evidence and theories, but we are unequivocally experts in evidence-based psychological therapies such as CBT. I think we could be even clearer, the competencies of clinical psychologists are now statutorily regulated by HPC (...)

I know that this is, of course, true for others branches of psychology. A near-identical statement could- and should- be made on behalf of the British Psychological Society Division of Counselling Psychology. And many other professions have members with skills. My principled view is that we should recognise and respect these competencies, and indeed be

prepared to learn, but that nevertheless it remains important for us to affirm our distinct expertise. (Kinderman, 2011b)

Although the CP leadership acknowledges the possibility of other professionals being skilled to provide CBT, it still claims that clinical psychologists are superior through their 'distinct expertise'. As seen at the beginning of this chapter, section 1.1, the uniqueness discourse used to construct the alternative model is also used to make CP practice dominant in relation to the other professionals in the internal therapy market. The alternative discourse of CP also constructs the other non-CP practices as different from CP, questioning their scientific basis, their ethics, and their ability to be creative and innovative. And the fact that CP needs to justify its expertise in these terms is an indicator that it places other providers of CBT and other evidence-based therapies, such as counsellors, CBT therapists, psychotherapists and even other applied psychologists, in subjugated positions. Using genealogy it becomes clear that this tension between CP and other providers of talking therapies is not new. For some authors it emerged in the 1940s when applied psychologists had to start providing therapies to attend the needs of a market that was being supplied by non-psychologists, such as religious groups and other organisations formed by lay people (Thomson, 2001); for others it was when CP embraced the scientist-practitioner model introducing Behavioural therapy in the 1950s after opposing the psychodynamic therapies available until then (Pilgrim & Treacher, 1992) but for most is in the eclectic phase of the profession in the 1970s, when humanist and psychoanalytical approaches also became part of the repertoire of the profession (Cheshire & Pilgrim, A short introduction to Clinical Psychology, 2004; Newnes, 2014; Pilgrim & Treacher, 1992) that CP had to justify its superior position within this market niche.

Another important observation about the use of the discourse of CP as CBT therapists in the quotes E23 and E24, above is the perceived threat of losing the area of work within primary care. Although not fulfilling the full potential of the profession as set out by MAS (1989), the expansion to primary care mental health was one of the recommendations of the report. MAS claimed that clinical psychologists supporting people with common mental health difficulties in primary care to be a public health function because it should reduce the number of cases of

serious and enduring mental illness that require secondary and tertiary care. E16, in section 1.2 above, talks about how this has not necessarily been the case because the group of people seen in primary care seems to be unrelated to the groups of people seen by secondary or tertiary adult mental health services.

Nevertheless, the gains for CP within IAPT were not only the possibility of ensuring the existence of professional jobs as CBT therapists. Indeed one of the premises of the IAPT project was to train other qualified mental health professionals, such as nurses and occupational therapists, to deliver CBT instead of training more clinical psychologists because this would be cheaper (Layard, 2005). The mental health professionals who received training to deliver problem-specific CBT intervention became known as high intensity workers (Richards, et al., 2010). Clinical psychologists who could demonstrate that had achieved this CBT competency level either within their doctorate training or by undertaking the high intensity therapy training could also work as high intensity therapists (Turpin, 2007). The levels of competency in specific CBT interventions were recommended by the clinical psychologists Anthony Roth and Steven Pilling (2010).

Another development within the IAPT initiative was the creation of the low intensity intervention worker role, in which graduate psychologists would receive training to deliver psycho-education and guided self-help based on CBT principles by telephone or face-to-face as part of the stepped-care approach (Richards, 2010). Relevant to this study's first research question, was the argument that conceptually the implementation of the low intensity worker role would challenge the assumption that everyone who experiences distress needs to undertake a full course of psychological therapy delivered by the most specialised professional and it was hoped that in training this new workforce, low intensity workers would be more representative of the demographic makeup of the local communities they attend (Richards, 2010). However the difficulties in achieving this may lie in the mistaken premises of the stepped care model and the construction of 'common mental health problems' and their treatability with CBT based interventions.

In brief, the stepped-care model of treatment delivery in primary care was developed from the evidence base and the recommendations of NICE guidelines (Richards, Weaver, Utley, Bower, Cape, Gallivan, et al., 2010). It basically proposes that

people suffering from 'common mental health problems', i.e. the diagnostic categories of 'depression' and 'anxiety' disorders, receive the minimum necessary level of psychological input that they need, meaning that if the lower level of intervention is not adequate they can move up through the steps to receive more specialised and longer term type of intervention (Richards et al., 2010). The model relies on continuous quantitative and qualitative assessment of the service user's presenting difficulties in order to make clinical decisions about stepping them up or down to access the most efficient level of psychological therapy (Richards et al., 2010).

Although counter-intuitive in terms of supporting a project that shares CP's expertise with other professionals, the project ends up promoting some CP skills: expertise in CBT, expertise in evidence-based practices, clinical governance, management, training and supervision to mention a few. The high level of training and clinical experience of applied psychologists puts the profession in the position of leadership of IAPT services (Turpin, 2007). This is a result of the use of the discourses of quality assured by the doctorate, clinical governance, NSF and NWW that have been around since the New Labour government of the late 1990s. Within this model experienced clinical or counselling psychologists are expected to assume the positions of managers, supervisors and trainers of low and high intensity workers (Turpin, 2007), as well as to deliver the more complex interventions that require the use of formulation and other therapeutic modalities besides CBT (Roth & Pilling, 2007).

Answering the first research question of this study, it seems that IAPT galvanised CP practice not only to establish and publicise its MAS level 2 skills, but also to aim for MAS level 3, albeit only in terms of providing talking therapies and not in using its analytical and strategic skills to identify and plan indirect interventions tailored to local population needs. The profession of CP established itself in a position of superiority and control. The popular stepped-care model formulated to organise the delivery of input to people experiencing 'anxiety' and 'depression' by Roth and Pilling (2007) is a clear example of the control that CP assumed over the IAPT drive.

Returning to the analysis of the therapy sub-theme, the statements in this section also show that the technique of formulation is frequently mentioned within the CP discourse to differentiate its professional practices from other practitioners who deliver psychological therapy. Formulation is aligned with the discourse of the CBT expertise, which in turn is closely aligned with the evidence-based discourse: 'psychologists place such evidence-based psychological therapies within psychological formulations which draw on a broad range of evidence and theories' (E24) and 'we've always had multi-dimensional formulation based approach, we've always applied science when we need to do.'(E17)

However, formulation represents, in discursive terms, the practical application of the broad and in depth theories and concepts of the profession as shown by its definition in E25:

[E25] Clinical psychologists use formulation with individuals, couples, families and groups. There is also a growing trend for using formulation in multi-disciplinary teamwork, both inpatient and community-based. In this, a group of staff is supported to construct a shared formulation for and with service users known to some or all of the team members. Formulations may also be developed and shared with professionals from other agencies and services – wards, hostels, schools, day centres, care homes, courts, and so on – and with the wider organisation in which the psychologist is employed. The quality of a formulation is dependent in large part on the quality of the assessment and the information derived from it. Clinical psychologists are expected to be competent to use a range of procedures such as psychometric tests, risk assessments and structured interviewing. Information may also be gathered from relatives and carers, other professionals, diaries, medical notes, observation, feedback from homework tasks, and so on. Quality also depends on supporting the service user (and sometimes family/carers) to convey their understanding of the difficulties as fully as possible, along with strengths and



resources. High quality formulations should also be informed by the most recent evidence, as summarised in NICE guidelines, Cochrane reviews and scientific journals. (Division of Clinical Psychology, 2011, p. 8)

The technique of formulation provides a practical means by which CP can operate at MAS level 3, beyond therapy and individuals. The genealogy of this technique indicates that its present form carries within itself a lot of the socio-historic construction of CP. Monte Shapiro, in the 1950s, developed the idea of applying experimental psychology principles to clinical intervention on a case-by-case basis which was an origin of the multi-theoretical formulation technique that is present in the discourse. Pilgrim and Treacher (1992) have discussed how Shapiro's original model got lost through service pressures and the turn to behaviour therapy simplified the process and behaviourist functional analysis was adopted.

Formulation also represents the eclecticism developed by CP with the inclusion of humanistic and psychoanalytic approaches into their repertoire in the 1970s, organising the variegated sources of theory and systematising practice to guide direct and indirect interventions. Nowadays, as per E24, E17 and E25, the use of formulation by pressurised professionals can legitimise the positivist knowledge claims of CP through its alliance in practice with the evidence base discourse.

[E26] (...) I think we're still really unclear about how we see ourselves because we keep on, as soon as we talk about evidence, we go round ..... individual patients, CBT versus other therapies, and generally talk about individual and community. There's a number of very, very important initiatives going on and the BPS and our profession is absent from them.(...) And I think some of that is about how we see ourselves and this debate about MAS and level 1 and 2 and 3, we say we should be doing more for level 3 stuff, on the other hand a number of the skills and qualities which are to do about that we've almost wholesale abandoned as a profession. (...) So we don't like doing lots of in depth testing and formulating or

whatever so we go down the route of doing post qualification ... therapy training courses .... which is very much honed everyone to the skills and getting away from the bigger picture itself and I think ... what do we do, I think that a lot of the way, I think we're very much under pressure, we're very much like "oh poor me, poor me" so how we try and get more power is by standing at the party next door to the powerful psychiatrist trying to do more for [inaudible] I think we need to think more about how we can sell ourselves(...) (DCP Colloquium June 2011- Katrina Scior)

The analysis of E26 reveals much about the internal conflicts within the profession, identity confusion and disagreement about the scope and use of their science. Of particular importance is the indication in E26 of '(...) we go down the route of doing post qualification ... therapy training courses(...)' , describing that Continued Professional Development (CPD) practices are leading CP to trap itself in continuously improving their MAS level 2 skills, by doing more specialised therapy training courses, rather than investing in MAS level 3. Again it is the tradition of the professional practice, the dominant discourses determined by the historical construction of this identity of therapy provider, which limits the inclusion of MAS level 3 skills. With regards to the apparent '(...) we don't like doing lots of in depth testing and formulating or whatever(...)' (E26), skills corresponding to a MAS level 3, if one considers this statement within the discursive realm and not phenomenological, there would be a series of discourses supporting this construction. Although E26 does not provide clear evidence about service pressures, as mentioned in Chapter One, section 3.1, Pilgrim and Treacher (1992) had already identified this had being responsible for limiting the practice of complex single-case analysis. More about service pressures will be discussed below in section 2.3.

To summarise the findings of this section and answer this study's first research question, it appears that CP has not moved to a clinical practice consistent with a MAS level 3 skills set. This is possible due to a combination of the dominance of the positivist evidence-based discourse, the alliance between well-being and

Cognitivism, the credibility of the clinical psychologist as therapists delivering CBT and the scale of the IAPT service that together create conditions of possibilities for CP to be in leadership roles. Although the conditions created by the interaction of these discursive themes, within the context of the current institutional practices and the historical contingencies described in the next session, also contribute to limiting the reach and scope of the profession's leadership discourse. Within this context and discursive alliances, CP professional practice reinforces the discourse of the delivery of therapy services, consequently reducing the power of the discourse of the more complex and indirect practices at MAS level 3.

Moreover, the profession engaging in IAPT, practicing CBT and doing more post-graduate training in these approaches, as required by the service model, is in conflict with the idea of formulation and its tailor-made approach discourse, which would be more consistent with the use of a MAS level 3 skills set. This analysis has indicated that CP practice could possibly be understood as becoming more a disorder specific approach rather than a person-specific approach because of the professional focus on CBT, in which ready-made pieces of intervention are put together to address the service user's needs rather than actually tailoring the intervention from scratch, drawing on the broad professional knowledge base. The DCP guidelines on formulation (DCP, 2011) do mention this exact conflict and relate them to the increased use of problem specific formulations within the CBT/IAPT model rather than an all encompassing understanding of the person and of their distress. Looking back in the history of CP there have been discussions about ways of avoiding the disorder specific approach since the 1980s. For example Owens and Ashcroft (1982) suggested that using functional analysis would avoid the focus on specific types of problems and the theoretical preferences of clinicians.

This disorder-specific approach does seem to be valued within the fast pace and high demand of the still scarce CP services. In the next section I turn to the analysis of two key recent historical and institutional changes which creates further conditions for the limitation of clinical psychologists' practice to disorder-specific and individualistic models of care.

## 2. HISTORICAL CONTINGENCIES

In this section, I answer the second research question by analysing and discussing two recent and significant historical contingencies that were identified as influential within the data. The first one is the DCP's proposed 'paradigm shift' in 2014 and the second is the 'any willing provider' change of the commissioning system within the NHS in 2011. References to these two contingencies were repeatedly found within the discursive themes identified by this Foucauldian informed DTA. They have been presented in this section in no particular order and their analyses provide further evidence for the conclusions reached in the section above. Quotes of data extracts will demonstrate how discursive themes were used within the context of these contingencies.

### 2. 1. 'Paradigm shift'

One recent historical contingency identified was the release in 2013 of a public statement from the DCP criticising the use of functional psychiatric diagnosis (Division of Clinical Psychology, 2013). The analysis of this positioning statement reveals conflicts at the core of the practice of British CP and the profession's discursive sub-theme of problem, disorder and abnormality.

The DCP statement contextualised and problematised the issues of the use of diagnosis. In this unprecedented public criticism of the concept of functional psychiatric diagnosis by CP's specialist division within its professional body, the DCP, challenged the status quo within mental health services. The statement exposed the theoretical and practical limitations of the categorising system when the positivist medical model was applied to matters of human distress.

[E27] Many of the issues that arise in relation to psychiatric diagnosis stem from applying physical disease models and medical classification to the realms of thoughts, feelings and behaviours, as implied by terms such as 'symptoms' and 'mental illness' or 'psychiatric disease'. (DCP, 2013, p. 1)

In the statement, the DCP exposed the ambiguous historical origins of psychiatric diagnosis and even acknowledged that applied psychologists contributed to that by making use of diagnoses within their practice and research.

As much as challenging functional psychiatric diagnosis, the DCP's position statement also served to promote CP alternative discourse to a much wider audience, as revealed by E28:

[E28] In May 2013 we hit the headlines internationally with our Position Statement on Classification, and thanks to close liaison with the BPS Media Centre, were by and large successful in preventing this being dismissed as a turf war between us and psychiatry. The statement was widely welcomed. We were gratified by the support we received from other professional bodies and service user groups. The controversy has of course not gone away, and the Diagnosis working party will be building on the recommendations in the Statement in the New Year, so that we can continue to set the agenda in this important area. In 2014 we will have a new publication on "Understanding 'depression'" and an updated version of our influential document on "Understanding 'psychosis'". Both of these are aimed at a general audience including journalists, policymakers and the public. We hope that they will be a major influence on thinking and policy as well as a resource for service users and healthcare workers. (Pemberton, 2014)

By reaching wider audiences and aligning itself with other professionals and service users, CP's 'paradigm shift' discourse gives power to the alternative discursive theme, analysed in section 1.1, at the beginning of the chapter. Contrary to the assurances of Richard Pemberton about this not being a 'turf war' between clinical psychologists and psychiatrists, in discursive terms this can be considered a dispute for power by clinical

psychologists. As we have described in Chapter Two, section 2.1.1, Foucault considers that conflicts between professional discourses are part of the operations that order and organise discourses and practices. In this case the professional practice of CP claims to have knowledge of a better understanding of how to address people's distress within the field of mental health. This discursive strategy seeks to maximise the power of the profession not only to maintain the status quo but to bid for further professional territory.

Considering the mechanisms of discourse set out by Foucault (1981) and described in Chapter Two, section 2.1.1, it is necessary that CP grounds its knowledge in order to claim the authority to make such a statement, a necessary step for the professional discourse to gain power. To do that the DCP (2013) defines CP and its practice within mental health as shown in E29:

[E29] Irrespective of whether the psychiatric diagnosis refers to a condition with an established primary biological basis or not, there is clearly an identified role for psychological assessment, formulation and intervention in addressing psychosocial factors, taking into account the influences of biological contributions. The same pertains to applied psychology in health, where the role of psychologists is to identify, formulate and offer interventions relevant to the biopsychosocial factors that may predispose to physical illness and will materially influence its course, outcome and impact. (Division of Clinical Psychology, 2013, p. 3)

In E29, it is diplomatically stated that psychological support can take place regardless of diagnosis. In stating this the practice of CP is put in a position of being liberated from using diagnosis and finds another justification for the discourse of alternative. Assessment, formulation and intervention are some of the alternative tools described by the statement. These three techniques of CP practice, already analysed and discussed at different points in section 1 above, are not free from the

influence of the socio-historical construction of the professional practice and Positivist discourses of Science. Because the DCP statement was made to challenge diagnostic categories and proposed a 'paradigm shift', it is of particular importance here to make more explicit the relationship between the professional practice of CP and the discursive sub-theme of disorder, problem and abnormality.

### 2.1.1. Disorder, problem and abnormality

The analysis of the 'paradigm shift' contingency revealed the presence of another allied discursive theme: the discourse on disorders, problem and abnormality which were briefly mentioned when the discursive theme of Cognitivism and therapy were discussed respectively in sections 1.2.2 and 1.2.3, above. The disorder discursive theme allies itself to Positivism and refers to the conceptualisation of human distress as outside normalised standards. The genealogical analysis of the disorder discursive theme demonstrates how it has been used by the practice of CP in the UK. The clinical practice of CP that relies on understanding human distress as problematic and based on disorders will be discussed in this section as constructing subjects in a manner similar to the practice of psychiatry, which the profession tries to construct itself as independent from and as an alternative to.

Although the DCP document firmly advocates a shift from a position of reliance on the psychiatric classification systems, in reality and as already noted by Newnes (2014), it does not ask its members to stop using them. Indeed, guidelines in use until recently (E30) recommend the use of diagnoses as a way of communicating with other MDT members in meetings and even to use them to write clinical notes.

[E30] 4.4 Practitioner psychologists may identify and record one or more mental and behavioural disorders relating to each individual as necessary, using standard diagnostic classification systems, and record these in client records, either on electronic systems or in paper notes. They may also use them in reports to the courts or other agencies. (BPS, 2012)

This confusing position about the use of diagnosis and the historical origin of British CP within a health service dominated by a psychiatric discourse (Pilgrim & Treacher, 1992) has created a view of CP as mentioned by the profession's leaders in 2011 (E31).

[E31]‘(...), if you type in clinical psychology and go to the health pages up until recently they said “clinical psychologists diagnose and treat mental illness using a range of therapeutic techniques” and in a sense we’re still in a react mode to that, we’re still saying no that’s not all we do, we don’t actually diagnose mental illness and we don’t treat and actually it’s not [inaudible] , what we don’t do is we don’t say psychology is a profession that applies itself to some of the world’s greatest problems. We are people passionately engaged in social justice, blah blah blah. So we’ve tended to be in react mode rather than positive looking forward mode and maybe the way of leaping over these problems about commissioning is to simply not go from the bottom up where they can cut us off in arguments all the way up but to go for that more social justice, human beings are human beings, human beings live in a social world, all of that sort of stuff, it’s maybe a better strategy to get that message across and I’m as guilty as anybody else that we haven’t been developing what clinical psychology is from that perspective(...) (DCP Colloquium June 2011- Peter Kinderman)

There is still a lot of misleading and confusing information circulating for the public. The following extracts are a sample of the information available on the profession, E32 from the DCP and E33 from the NHS website.

[E32] Every day clinical psychologists help a wide range of people of all ages with all sorts of problems. Some have particular emotional or mental health problems, such as depression or schizophrenia. (Division of Clinical Psychology, 2010)



[E33] Clinical psychologists aim to reduce psychological distress and enhance and promote psychological well-being. They work with people with mental or physical health problems which might include: anxiety and depression[;] serious and enduring mental illness[;] adjustment to physical illness[;] neurological disorders[;] addictive behaviours[;] childhood behaviour disorders[;] personal and family relationships. (Clinical Psychology, 2014)

E32 and E33 show how these definitions construct a practice around problems and disorders, even if not directly using diagnostic terminology, although there is a noticeable use of 'schizophrenia' in E32. E9 above in section 2.1.1 also talks of how CP focuses on problems. CP also uses the term 'presentation', for example E9 and E22, above respectively in sections 1.1.1 and 1.2.2, and the idea that certain types of presentations respond better to different kinds of intervention guide practice. These all reveal the inherited Cartesian epistemology of CP that developed in mirroring the theories and principles of medicine and its applied practice of Biology (Hearnshaw, 1964; Pilgrim & Treacher, 1992; Rose, 1985).

Rose (1985), using genealogy, identified that psychiatry as a medical profession embedded within positivist logic, makes use of Cartesian theory that understands a straight and clear dichotomy between health and illness and makes use of a diagnostic classification method to explain human experience. Similarly, applied psychology within the clinic and laboratory in the early days made use of the conceptualisation of normality and abnormality to explain individual differences and behaviour (Cromby et al., 2013; Newnes, 2014; Pilgrim & Treacher, 1992; Rose, 1985) and although psychology did not develop a classification system of its own, it reinforced and legitimatised the use of functional psychiatric diagnosis simply by continuing to make use of it (Rose, 1985).

The discourse of 'disorder' and 'abnormality' within CP comes from the profession's origins as an auxiliary profession to psychiatry (Rose, 1985), constructed within this relationship, mirroring the methods of the medical science and influenced by the

dominant ideas of the 19<sup>th</sup> Century *zeitgeist*, such as *Eugenics and Social Darwinism* (Hearnshaw, 1964; Newnes, 2014; Pilgrim & Treacher, 1992). Within the psychiatric practice, an early version of applied psychology that developed into current CP was constructed as the applied science of ‘abnormal psychology’ (Rose, 1985; Pilgrim & Treacher, 1992; Pilgrim, 2008).

To conclude, the CP as an alternative discourse, constructed in opposition to the psychiatric model and its diagnostic terminology, still has within its practice a powerful presence of the disorder and problem discourse. The power of this discourse is increased by the profession’s close ties with the evidence-based discourse discussed above in section 1.2.2.; e.g. the Roth and Pilling (2007) stepped care approach is based on ‘anxiety’ and ‘depression’ presentations, the publication of BPS documents on ‘Understanding ‘depression” and ‘Understanding ‘psychosis” (E28). CBT proficiency, now at the core of CP qualification and the growing and influential IAPT practices, all contribute to this continued construction of ‘depressed’ and ‘anxious’ subjects, to mention a just two few of the diagnoses or presentations recurrently used.

Pilgrim (2007b) also concluded that the extent by which CBT dominates the practice of CP nowadays is also a contributing factor to the perpetuation of the influence of psychiatric diagnostic categories. The author also points out that the research production of CP is influenced by the current socio-historical context in which medical practice, backed up by the heavy support of very lucrative pharmacological industry, exerts control over how research is funded and published. ‘Those clinical psychologists who seek research grants for their interventions will have to operate in a context in which medical authority allocates resources according to the gold-standard methodology of randomised controlled trials in clinical populations. The latter populations must be carved at the joints of DRGs [diagnostic related groups] to warrant grant allocations.’ (Pilgrim, 2007b, p. 544)

Although seemingly distant from the origins within ‘abnormality’ and psychiatry, the socio-history of the construction of the disorder discourse is still very present within the techniques employed daily by CP, therefore perpetuating its power. In fact, Carr

(2012), a very popular author of CP textbooks, has recently released a comprehensive book on CP in which its chapters are organised in diagnostic terms.

## **2.2. 'Any willing provider'**

A second historical contingency identified as repeatedly mentioned within the discursive themes identified within the data referred to the changes within the NHS internal commissioning system which we call here the 'any willing provider' policy.

The discursive sub-themes and practices constructed in response to the 'any willing provider' historical contingency identified the recurrence of historical tension between the small numbers of clinical psychologists and their distribution in terms of their seniority grades, which correspond to the implementation of the professional practice at ever increasing levels of complexity and sophistication. The discursive sub-theme of partnership with service users, carers, grass roots and third sector practices was also identified as relating to this historical contingency. The analysis and discussion of these discursive sub-themes in this section indicate that they create the conditions of possibility for CP to consolidate its discourse of alternative practice and to use its MAS level 3 skills to address local needs of health prevention and promotion.

Since the structural changes proposed to the NHS in 2011, the public and the staff involved in the NHS have demonstrated a lot of concern as seen in the quotes in section 1.2. Clinical psychologists among them have also been worried about the impact of the changes on their clients, services, careers and jobs. However, amongst the leaders of the profession the discourse constructed has been one of opportunity for CP to implement its alternative approach and use its leadership skills (E34, E35).

[E34] (...) a time of necessity is also a time of potentially creativity (...) this crisis and the changes in the NHS might be an opportunity for CP to be creative and for their service to 'thrive' (DCP Colloquium June 2011- Jennifer Clegg)

[E35] The mantra amongst NHS managers for 2014 is let's not waste a good crisis. In my opinion the same is true for Clinical Psychology. The current pressures and sea of changes provide us with a real opportunity for us to modernise and collectively raise our game. (Pemberton, 2014)

Constructed as hopeful and positive: 'opportunity for CP to be creative' (E34), 'let's not waste a good crisis' (E35), 'modernise and collectively raise our game' (E35), the profession of CP is portrayed again as unified, flexible and resilient, able to overcome the institutional, organisational and bureaucratic challenges ahead. These statements are consistent with the alternative discursive theme analysed in section 1.1 and this positive and encouraging leadership discourse also subjugates the discourses and practices that appraise the imposed government measures as challenging. Among the challenges identified by the DCP chair in 2011, Peter Kinderman, are the commissioners' confusion about CP's role and CP's lack of power due to its small number as shown in E36, E37, E38.

[E36]The NHS has a problem meeting with psychologists because there are so many different professions in mental health care that simply meeting all of them all of the time tends to get quite difficult and whenever there is a meeting there has to be 27 people in the room and it just gets a pain. (DCP Colloquium June 2011- Peter Kinderman)

[E37] So when people write stupid things on a [...] and say why doesn't the BPS convene a meeting with Andrew Lansley, Paul Burstow and Richard Layard. It's because when we write them a very polite letter saying would it be a good idea to meet. They say could you please sod off and stop writing us these trivial letters you're just not important. (DCP Colloquium June 2011- Peter Kinderman)

[E38] The message from me is that I think what we've got to offer as a profession is quite valuable, quite different,

distinctive, valuable there's a really weird confusion in the NHS because what they say they want to buy is exactly what we've got on offer and then when we present it to them they say 'nah sod off we want to buy something cheap that works thank you very much'. It's really quite bizarre. (DCP Colloquium June 2011- Peter Kinderman)

The statement 'what they say they want to buy is exactly what we've got on offer' (E38) may represent the tension analysed above about the powerful combination of the discourses of alternative, leadership, well-being and evidence base with the discourse of CP as therapists and 'diagnosticians'. The response "nah sod off we want to buy something cheap that works thank you very much" (E38) is consistent when responding to CP as therapist discourse, as CP is a relatively more costly than other providers of therapy. This 'really weird confusion' (E38) relates to the apparent lack of external power of the profession alliance with the dominant discourses. This again reveals the tension between the applied scientist and therapist discourses and explains the strategy of the profession to at times distance itself from the therapist discourse as suggested in section 1.1.1 above.

However, this discursive tension caused by the incoherence of the professional practices and discourses is often misattributed to the idea that the profession is 'just not important' (E37). This professional rhetoric has been endorsed by previous historical analyses as seen in Chapter One, section 2.3, such as Hall et al. (2002) who stated that CP profession does not believe in itself.

[E39] (...) the focus of our employers at the moment is about 'bums on seats' and getting people through the system, and that actually they're not that interested in the stuff we are good at, the stuff we try and sell ourselves on which is the indirect working, so there's a bit of a problem. (DCP Colloquium June 2011- Mike Oldridge)

[E40] If you believe that nothing is going to happen then you won't bother getting involved (...) but if we have not only Cuts

Watch but also a kind of almost template DCP response and you know the sort of thing we want because the thing we see with other medical royal colleges when their services are threatened then we get on the right side of that loop. (...) if we have an ethical basis rather than a sort of self serving basis for it then you know we talk about the importance of maintaining adequate services for more vulnerable clients. (DCP Colloquium, 2011 – Peter Kinderman)

E39 indicates that this continues to be the case as the NHS is 'not that interested in the stuff we are good at' and about the attempts described in E40 to make the professional 'believe' in themselves and in their professional body that is quoted as if it was '(an)other medical royal college'. The idea of a Royal College of Psychologists has regained momentum recently. The idea of forming a College of Healthcare Psychology had been already proposed by Derek Mowbray in 1990, who recognised that similar proposal had been made in 1977 by May Davidson (Mowbray, 2011). The Royal College of Psychologists Campaign Group (Royal College of Psychologists Campaign Group, 2016) proposes that the BPS should structure itself in a similar format to other Royal Colleges, such as the Royal College of Psychiatrists or Royal College of Nursing. This move would mean bringing the statutory regulation of applied psychologists to its professional body from the HCPC. Having a Royal College of Psychologists would mean the official protection of the title of 'Psychologist' which would increase even more the power of the professionals, their discourses and practices to maybe help them to be heard in the higher circles that seem to subjugate CP's discourse. The BPS in 2014 has consulted its members about this proposal (Royal College of Psychologists Campaign Group, 2016).

Another important fact to consider about the increased momentum of such a proposal revisits the discussion of section 1.2.3, about the impact of the increasing competition within the NHS market. After the implementation of the IAPT service model, clinical psychologists faced competition from non-applied psychologists, i.e. those other professionals or psychology graduates who receive training in CBT, to deliver psychologically informed CBT interventions at a lower cost. The 'any willing

provider' commissioning policy makes the possibility of competition for the professional psychologists' territory even more present.

Information from the DCP Managers' Forum survey in 2011, E41 below, indicates that the reality within the job and career prospect of CP imposes limitations on the profession's opportunities to use their alternative and leadership discourses and fulfil MAS level 3 aspirations.

[E41] We've found significant findings in terms of staff being lost, roles being lost, posts being downgraded and there's sort of a 50/50 rule that about 50% of services have been losing posts, for instance 8c and above posts are all gone. 56% of respondents are seeing a decrease in staff and I think this is significant, it's a 50% but only 50% felt they had a strong leadership identity and the thing that's most strongly correlated across with services that were either sustaining staffing levels or growing as opposed to those that suffered cuts was about the kind of leadership in their specialty. I don't know you do it but I think the clear message is this, that there needs to be an emphasis on increasing leadership profiles within our services [inaudible low voice]. If senior staff are being lost clearly this is leading to losses within the service around strategic thinking, clinical leadership, innovation [inaudible] was talking about, an alternative to medical model thinking and again the clients who senior staff will tend to see are the ones with more complex issues, the vulnerable clients, and that level of expertise is getting lost. (DCP Colloquium June 2011- Mike Oldridge)

The statement shows how the optimism and opportunity within the alternative discursive theme contrast with the reality expressed by the clinical psychologists leading frontline services (E41). The issue of cost of CP is a recurrent tension between CP and the commissioners.

Within this new context, the mention of other discursive themes that would enable the implementation into practice of the discourses of alternative and leadership were identified within the data.

One discursive strategy identified within the analysis of the data was the alliance of CP practice with the practices of the charity sector. The practice of establishing partnerships with non-statutory services is already included as part of MAS level 3 work practices (MAS, 1989) however within the context of the 'any willing provider' CP finds a new force towards this as seen in E42 and E43.

[E42] In 2014, our User and Carer group will implement its new strategy, which will be more driven from the grassroots. All our subsystems need strong user and carer input and representation. Commissioners often dismiss professional arguments as special pleading. Service User and Carer groups are a powerful voice in the new system and provide a useful check and source of challenge to the development of the kind of clinical psychology that people want and need. The new strategy will strengthen our alliances with influential groups such as Mencap, Young Minds, Headway, Rethink and the Alzheimers Society and their equivalents across the four nations. (Pemberton, 2014)

[E43] So do we have to be part of the NHS [inaudible]. This comes back to your point about we don't want services from outside the NHS. The vast bulk of commissioning, the reason why we said that we dislike competition in the NHS is because our clients are very vulnerable so I think we are talking about the use of state money but it could be in social enterprise's, it could be BUPA, it could be Turning Point, I've got nothing against Turning Point, if we think, decide to set up a service, we think I've got a great deal (...). (DCP Colloquium June 2011 – Peter Kinderman)



‘Service User and Carer groups are a powerful voice in the new system’ (E42) and alliances with them and ‘influential groups’ (E42) are constructed as opportunities for ‘the development of the kind of clinical psychology that people want and need’ (E42). The alliance of CP discourses with the discursive sub-theme of partnership could be a powerful strategy for CP to place its skills in the leadership within the NHS and implement its alternative discourse. Although the profession leaves its strategy unclearly open for a self-serving use as ‘Commissioners often dismiss professional arguments as special pleading.’

Nevertheless, partnership with the third sector relies on different sorts of discourse to the dominant science, evidence-base, Cognitivism and therapy discourses that were identified as part of the profession’s discourses. ‘Grassroots’ and ‘strong user and carer input and representation’ possibly allow for the construction of a different practice of CP, less focused on the maintenance of its professional territory. It is within the promise of this discursive alliance that possibilities are opened up to implement practices beyond the individual delivery of one type of psychological therapy in a broader system.

## Chapter Four: Final considerations

### 1. SUMMARY OF FINDINGS AND CONCLUSION

*Alternative* and *Leadership* were identified as the main dominant discursive themes of CP in the present time supported by the discursive sub-themes of applied scientists, well-being, Cognitivism and the practice of therapy. The analysis of the tension between these discursive themes and of their socio-historic construction revealed a recurrent use of discursive strategies to keep the professional status quo and gain more power. The impact of IAPT, austerity measures and increased competition within the NHS market is a continued struggle for professional power that ends up strengthening CP's MAS level 2 skills (proficiency in the delivery of psychological therapies), whilst compromising the potential of the profession to operate more strategically and beyond the provision of therapy in a MAS level 3 professional capacity.

The *alternative* discursive theme constructs a unified facade for CP in which the conflicts and disputes within the profession are obscured. CP is constructed as unique, creative, innovative and ethically and scientifically sound in relation to all the other non-CP approaches within State services. It is in the high quality of the *applied science* discourse, which construction is based on the analytical and research skills benchmarked through the professions' doctoral level of training, that the alternative discursive theme finds force to become more powerful than the other practices.

The *applied scientist* discursive theme of CP is privileged in relation to the provision of psychological therapy. A recurrence of the original struggle between the discourse of science and therapy is encountered in the profession's present. However, the power relation between these discursive themes appears to be inverted versus their original conception in the 1950s (the inclusion of therapy into a scientifically dominated practice). Nowadays it is the distancing from the therapist practice and a strengthening of the applied scientist discourse that is evidenced by the analysis.

The analysis of the *leadership* discursive theme confirms the dominance of the discourse of science in relation to the *therapy* discourse, however in an inconspicuous way. The *leadership* discursive theme, relying on high quality scientific knowledge claims, supported by the academic training at a doctorate level, allies itself closely to the positivist *evidence-based* discourse. The increased connection of science and administration within state institutions since the late 1970s, has contributed to the increased dominance of CP's leadership discourse and consequently practice of MAS level 3 skills over the years. However, the construction of the *Cognitivism* discourse to the physical sciences and the facility of CBT to produce data to justify this scientific discourse led to the narrowing of the evidence-base for the profession. The evidence-base and scale of IAPT services drive the professional discourse of CP to ally itself closely with these dominant practices and discourses. CP's part in the leadership of IAPT and claims of expertise over well-being resulted in the dominance of the profession's therapeutic skills in relation to the more complex and broader application of scientific principles to each scenario encountered in the clinical practice. Therefore it is within this power play between the discourses that CP ends up fixated on MAS level 2, compromising the very scientific principles that the profession has for itself at MAS level 3, evidenced by the tension between protocol based therapy delivery and the development of formulations.

The analysis of the DCP's proposed 'paradigm shift' in relation to the use of psychiatric diagnosis reveals the tensions at the core of the practice of CP that is still based on the problem, disorder and abnormality discourses of the profession's socio-historic construction. The analysis of the discursive themes and practices constructed in response to the 'any willing provider' initiative identified both recurrence of historical tensions of numeric power, carer progression and practice from outside the NHS. The discursive theme of partnership with service users, carers, grass roots and third sector practices does, however, open up the possibility for CP to use its MAS level 3 skills to implement a truly alternative discourse, beyond the non-psychiatric discourse, and to address local needs of health prevention and promotion.

In summary, professionalization and the dominance of positivist discursive themes within the apparatus of the State limit CP's progression from MAS level 2 to MAS level 3. The defence of the professional 'territory' leads CP to ally itself conveniently with the dominant discourses of the time and State ideology. This approximation limits potential CP practice to therapy. CP as a technology of the body has its discourses, practices and techniques in use to continue the production of 'disorderly' subjects that are in constant need of therapy.

## **2. EVALUATION**

In this section we return to the criteria for evaluation of qualitative research set in Chapter Two, section 4, and compare this study against the guidelines recommended by Spencer and Ritchie (2012).

### **2.1. Contribution to the knowledge base**

In terms of contribution to the knowledge base, this study has achieved its aim and provided a picture of the current discursive and socio-historical influences of the professional practice of CP in the UK and answered the questions about the direction the profession has taken in recent times. The findings here have echoed some of the findings of Cheshire and Pilgrim (2004) and Newnes (2014), it identified that dominant discourses of individualism within the profession supported by the discourses on science and the need for professions to survive in a market are key to defining how CP operates in practice. This was achieved using a different method that allowed for the detailed examination of the discursive themes and their operations of power. This Foucauldian informed DTA also has added a 'live' dimension to the discussion of CP professional strategic discourses because it investigated these operations in a historical time of systemic turmoil identified as a structural field of conflict.

This study has explored in more detail the mechanical operation of the discourses and how their alliances empower the profession to keep the status quo of being

experts in providing evidence-based therapy to the detriment of a full analytical and strategic role within the NHS. The operations of the discourses have possibly answered the question posed by Hall et al. (2002) about who is being served by this current practice of CP. The findings here indicate that it is actually the State that benefits from this individualization of problems, using the techniques and theories developed by high skilled profession to deliver some of its ideologies at low cost.

## **2.2. The study's credibility**

In terms of the credibility of this study it is important to evaluate the data selection and the clarity of the analysis. The aim of this study was to focus on the professional issues encountered within the area of adult mental health and the systemic turmoil of the changes within the NHS in the present time. Within this specific focus this study has reflected how CP practice is constructed through the analysis of the discursive themes used by the profession's leadership in response to some of these changes.

The public opinions of at least three recent DCP chairs were analysed and discussed in Chapter Three. This analysis was complemented by data from the other influential sources within the archive of the profession, such as textbooks and professional, educational and governmental guidelines and policies. These were used to contextualise or explore in more depth the specific discursive themes identified within the quotes from the colloquium transcript. Although not all the discursive themes encountered within the literature and used day-to-day by clinical psychologists were analysed here, a relevant sample of the key discursive themes used by those interested in the professional organisation of CP in the UK have been analysed.

## **2.3. Rigour of the analysis**

Rigour in the conduct of this study was demonstrated by continuously checking that the data and analysis were viewed within the methodological assumptions established in Chapter Two. I have ensured that I kept the analysis and discussion

consistent with the concepts of general history and organisation of discourses. I have avoided exploring hidden meanings, making inference of intentionality and establishing simple causal relationships when I analysed the relationship between discursive themes and their trajectory through the recent history of the profession of CP. The evidence for this is encountered in the description of the conflicts and contradictions between discursive themes identified by this study. The findings presented here revealed the complexity of the systems which are responsible for the development of the profession of CP and how they are influenced by macro societal discourses and processes of professionalisation.

To ensure that this study could be audited and its findings verified or replicated by others, I have taken care to include very long data extracts within the analysis in Chapter Three. A sample of the transcript of the colloquium, the source of the majority of the quotes, can be found in Appendix II, with the notes made at the initial stages of the data analysis. I have also added in Appendix IV, a table in which the sources of the quotes used are clearly referenced.

## **2.4. Epistemological and personal reflexivity**

In this section I draw on Willig's (2013) guidance for researchers on reflecting over how their assumptions influence their research and how in turn the research impacts on the researcher. To remain consistent with the critical realist social epistemological stance the process of conducting a DTA based on the concepts of Foucault, does not allow for the use of personal reflections to influence the analytical process because it is non-interpretative and non-anthropological (Kendall & Wickham, Using Foucault's methods, 1999). Within the realist position, my experiences, opinions and interests as someone who is training to be a clinical psychologist had to be suspended to allow for the professional group of clinical psychologists to tell their story independently. The same is true for each individual clinical psychologist whose textual products were analysed here, this epistemological stance did not allow for the study of their personal motivation or for their interests to be analysed. Making the conceptual assumption that the publicly available textual sources, and their respective authors, would represent the profession of CP in adult

mental health within the period analysed, this epistemological stance obscured the factors influencing specific authors, such as their individual stories, personal interests, professional trajectories and political ambitions. The adoption of a different methodology, perhaps using interviews, and a different epistemological stance could potentially unravel those and question the deterministic nature of this realist position.

Also in terms of epistemological reflexivity I am aware that the formulation of the first research question has been focused on a topic in which I am particularly interested. I have had more than 10 years experience of working in the adult mental health field within primary, secondary and tertiary services and I have also had first-hand experience in piloting and implementing the IAPT service model in the UK. I have since been interested in the question of delivering direct or indirect clinical psychology intervention, in the form of psychological therapy or not, within public health services. To operationalised the different levels of CP intervention in this study I have adopted the MAS model of skill levels 2 and 3 merely as a convention to represent them, as they were the results of the main review of the profession since its development within the NHS. As an engaged and conscientious professional I have been aware of these as my likely influences when searching for documents, selecting the quotes and analysing the discursive themes. I have found reassurance of my neutrality from the data itself, in particular from the Colloquium transcript, because these themes that interest me were spontaneously brought up by the speakers as there was no set agenda to be discussed. I understood from this that the interest in investigating these discursive themes, their operations and power are not only mine but is something that I share with other clinical psychologists who are interested in their profession.

In terms of personal reflexivity I have explored how my personal curiosity to investigate the profession of CP in Britain, having originally studied and trained as a clinical psychologist, in another country, may have influenced the research. Being originally from a different socio-historic context, I have reflected over my interest in investigating the British practice of CP and its discursive processes. The adoption of a Foucauldian informed DTA method which is non-anthropological (Kendall & Wickham, Using Foucault's methods, 1999) would provide me with the neutrality and distance from the object being studied to conduct a rigorous study.

A final element of my personal reflexivity is the impact of the process and research findings on my own professional practice as a trainee clinical psychologist. The better understanding of the micro operations of power on my everyday practice allowed me to address some of the tensions which I encounter around delivering services at MAS level 2 and MAS level 3.

### **3. STUDY'S LIMITATIONS**

This study is another case of a professional analysing their own profession that is recognised as a limitation but this is a common limitation encountered in the literature on the subject. Another limitation is the choice of the documentary material. This thesis attempted to use a diverse range of material from different parts of CP's system (Appendix IV), however, as it is a study of the present, a lot of the data comes from the same sources that may represent the interests of the people in the leadership of the profession during the time of the study. This may clarify the reason certain discourses were found to have more power than others, i.e. this study discussed a lot about wellbeing, therapy and IAPT and not about the Recovery model, nor the role of Responsible Clinician.

Another limiting factor of this study was the representation of the professional practice of adult mental health clinical psychologists through the data analysed here. Issues about the data selection have already been mentioned in section 2.2, above. Although the use of different sources of data was identified as giving credibility to the findings, it can also be considered a limiting factor. When considering that the data corpus of CP could be any publicly available textual production by clinical psychologists in the UK within the period analysed (2009-2014), this is vast amount and it may have not been represented here in their entirety.

Another point of limitation is that the statements of a few authors appeared to have been over emphasised within the analysis because of the leadership position they held within the DCP and other organised bodies during the period studied. It was assumed that discursive themes used by these leaders were commonly shared by the clinical psychologists working within the UK system. It was also assumed that



those who have participated in the production of official texts and have taken part in discussions organised by CP professional body, such as the DCP colloquium debate (used extensively within the analysis) reflected the dominant discursive themes used within the profession.

#### **4. IMPLICATION FOR PRACTICE AND POLICY**

The results presented here are of fundamental importance to the daily practice of CP and the training of clinical psychologists. Equipping professionals with the knowledge of their socio-historic construction and how their minute everyday practices contributes to the perpetuation of the very discourses (e.g. psychiatric diagnosis) that they try to oppose. The findings here could add to the argument for the compulsory teaching of Epistemology, history and of a broader range of scholastic methods of inquiry to break from the limitations imposed by an ever increasing positivist lead practice. Also in terms of training, the findings suggest that the over focus on the development of expertise in CBT to establish the dominant position of CP within the organisation of adult mental health services may hinder long term acceptance of other forms of intervention that clinical psychologists could develop and deliver in primary, secondary and tertiary care.

In terms of policy, it would be important for the profession and its organising bodies, the BPS, the DCP and the HCPC to continue to pursue ways to have their discourses heard in the higher circles of power, such as the government, DH, foundation trusts and commissioning groups in order to educate people about the MAS level 3 skills base, the broader understanding of evidence and to continue to build on evaluating indirect practices. The findings of this study indicated that the scientist-practitioner identity needs to be understood and explained to commissioners in its broadest sense, which would mean that the scientific production of CP within the clinical setting should be valued and protected, instead of being put aside by the pressures to deliver evidence-based interventions. In practical terms this may mean promoting and protecting CP's role in the production and dissemination of new forms of intervention grounded in the reality of the everyday clinical practice, building on practice-based evidence rather than over focusing on

evidence-based practice, which would contribute to opening up possibilities for the profession and the public it serves.

## **5. FUTURE RESEARCH NEEDS**

There are several ways to continue this history of the present. Following Foucault's concepts the idea of conducting Archaeology of a single discourse or practice identified by this analysis, such as Cognitivism, would reveal more about the discursive construction and its power. Alternatively, the analysis of the subjugated practices identified here: counselling, psychotherapy, critical and community psychology approaches, service user lead initiatives and to some extent even the other regulated applied psychologist would reveal more about their discourses and production of subjectivity that go against CP's, revealing even more about CP's practices.

A discursive theme mentioned only once within the data set was the professional practices of the clinical psychologists who work privately and independently from the NHS. It would be interesting to analyse the discourses of the professional practice independently from its originating institution which could reveal invaluable information about the influences of the mainstream CP practice within the NHS. It would also be interesting to examine the influences within the profession on a micro political level, in actual daily tasks, in particular systematic application of the clinical tools and techniques of CP. This could be done through the interview, observation or analysis of the documentary material used by a sample of clinicians in the field.

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## **APPENDIX I: Transcript convention**

Here is the convention for the simple transcription of the DCP Colloquium which was adapted from Banister et al. (1994):

(.) Pause,  
 (?) Query,  
 [] provides context with information inserted between the brackets,  
**[inaudible]** Inaudible section of transcript,  
**emphasis** Word spoken with emphasis,  
**[laughter]** Laughter during the presentation or discussion ,  
 <> brief interruption by another speaker,  
 / Other interruptions and overlapping talk

To clarify at times within the quotes used in Chapter Three, the use of (...) within the text of the quotes only represent the referencing convention of removing parts of the text that were deemed not relevant to be presented. In most cases when (...) was used indicated that the quote was reduced because their authors made long deviations from the point they were originally making.

## **APPENDIX II: Sample of analysed transcript**

### **[Theme of 1<sup>st</sup> round of presentations: The human cost of the proposed health service reform]**

#### **[Introduction - Dr Jennifer Clegg, Associate Professor, Institute of Mental health, University of Nottingham]**

[Jenny Clegg:] Hello and welcome. My name is Jennifer Clegg, I work for the University of Nottingham and I have nothing so far (...) I've contacted Peter Kinderman and had a conversation with one or two friends and somehow I became the convenor of this meeting. I'm most grateful to all those we have been willing to, at very short notice, join in, trying to produce and get into the air a range of ideas that will act as a spur for us to talk together about the events that are unfolding and what, if anything, we think about it, if we have a shared view, and what we might do about it.

There's a sort of sense that maybe it's all over bar the shouting but I think there's a lot of people saying there are many layers to go, it's still possible the health and social care bill will be axed completely, and it has many stages to go through. We haven't managed to get any MPs or journalists here but in the inviting of them they were brought aware of our thoughts and proceedings and I gather one or two are starting to respond by asking for interviews in a radio station

I think it's worth us starting to think and talk and be as energetic as we can be and we are of course a **very small profession** but (it's also interesting that) Stephen Dorrell who I think is probably one of the more reasonable (...health ministers) in the past has an (autumn submission) for people with, vulnerable people who've got needs which certainly includes people with learning difficulties which is my background, so I think it's still all to play for.

Constructing profession as 'very small'

I've been interested in trying to think about what we might be wanting to do, I remember the first round of Thatcher cuts, I think it was Ken Clarke then who talked about there will be a parade of bleeding stumps, and there is a difficulty in a time of necessity, in a time of financial crisis of simply saying well cut everyone else but not me and it does seem to me **important that we have some dialogue other than just take there don't like it and so** we are trying to put into the air not only information as we see it and news about how the plans may affect our clients but also try to highlight where we can things that could change and things that might be different and where money is wasted and where things might be done differently and as I've been having some conversations in the room thinking **both about**

CP not reacting to crisis but profession trying to save itself?

Open dialogue, building a case

Using some of CP knowledge to argue the case for the impact of crisis in service users. Constructing CP as superior? Believing in it?

44 direct psychological treatments because you'll hear from a  
 45 number of people also psychologically minded care  
 46 formulation, things other than simply one to one direct  
 47 interventions and and the whole integration of the intellectual  
 48 formulation that psychologists quite often get involved in them.  
 49 When I did my BPS management training I was told, well that  
 50 was a while ago, I was told that psychologists were regarded  
 51 as like the creative part within a business model part of the  
 52 research and also part of the advertising, that they were an  
 53 engine of change and innovation, and I must admit I tend to  
 54 think about psychology service that I'm involved with very much  
 55 as doing that and so not wanting to get ourselves too trapped  
 56 by, yes evidence based information is important but actually  
 57 also we're the ideas factory if you want something new if you  
 58 want some new energy come to us and as ... you know we  
 59 need to have some sense of ... healthcare I'll come back to  
 60 CQC which I think is an (iniquitous) organisation that does  
 61 stupid things, isn't a guarantee of quality at all., you may have  
 62 different views about that and I think we probably all going to  
 63 share these views on service integration of the (?) markets and  
 64 that it(?) might be the way forward, it might not be. In reading  
 65 the health and social care bill because I thought I should and  
 66 it's very dull, it's 186 pages and, but I became interested in the  
 67 language so of course we know it's all about option and  
 68 competition but you look at the language promoting regulation,  
 69 imposing, specifying, it's written, all this tough language is  
 70 reserved for competition. We do have some data about  
 71 marketisation, we know that nhs trust's costs went up hugely  
 72 when we introduced the internal market , a recent kings fund  
 73 paper is talking about how vulnerable groups fall between as  
 74 you get a fragment service with lots and lots of competition our  
 75 clients are the ones that fall between and Peter Kinderman's  
 76 response to the listening exercise emphasises that as well . We  
 77 are concerned about that, what we know, from my clients, I'm  
 78 familiar with has this increased quality, this increased physical  
 79 quality to do with much larger numbers of people with much  
 80 more comfortable living standards. We know from  
 81 Winterbourne of course that abuse continues it started my  
 82 career in 1976 and last week it emerged yet again and  
 83 socialisation [for/ forest jones/ for all ?] it's simply talking about  
 84 social isolation, people with learning disabilities despite the  
 85 mainstreaming agenda don't have any different social networks  
 86 from the ones they've always had which is [crap?](6:45). And  
 87 we see this individualisation focussing on people with learning  
 88 difficulties but also failures of service coordination are blamed  
 89 on staff and then you import, in my case, transition workers to  
 90 do the transition from child services and they, the staff, simply  
 91 went on to [inaudible] an incredibly difficult task . But we see  
 92 that it's their failure to hold the thing together rather than a  
 93 failure of the structure that's actually very difficult to make

CP practice therapy,  
one to one direct  
intervention,  
formulation

[E] BPS  
management  
training, CP as  
'creative part (...)  
engines of change  
(...) evidence base  
(...) ideas factory(...)  
new energy'

At this stage  
profession's view  
is that 'is not good  
for clients'

Number push does  
not increase  
quality

PWLD did not  
increase social  
network

94 happen and those sorts of individual critiques continue. This is  
 95 just a quick graph, I think it's probably a bit disingenuous  
 96 actually but again after the kings fund document, thinking about  
 97 what you know[?]. Peter was saying to me we haven't got cuts  
 98 we've got efficiency savings, but what's the consequence of  
 99 efficiency savings, of course we do see that productivity can go  
 100 down rather than up although (7:20) it that development that  
 101 the health service [data?] can't see health service line  
 102 [politics?] [inaudible] I think you do need to not fall in with the  
 103 motion but the efficiency savings are [inaudible, George  
 104 Osborne??]

An interesting way  
to put the whole  
challenge into  
perspective... a  
positive spin?  
What does it  
mean?

105 Weak language! So where's the weak language of the health  
 106 and social care bill? Well now we talk about cooperation I think  
 107 the most mini [mouthed?] one is healthy [money?] is to  
 108 encourage persons to work in an integrated manner [giggles]  
 109 it's just so different from the 'impose/regulate/specify' and may  
 110 encourage persons to work closely with health and well-being  
 111 before and may encourage persons to work [something?] care  
 112 and then it [leaked/leaded?] to section 62 and [2]64 'duty to  
 113 cooperate', and I thought that will be interesting, and the only  
 114 people who have to cooperate are a couple of quangos [versus  
 115 Humme?] I think so, you know, we've got a long way to go in  
 116 thinking that the cooperation-integration can happen within the  
 117 structure of this Bill and may that is just to [inaudible] total of  
 118 the Bill is going to be a clear role in [inaudible]. We do know  
 119 that there is a really interesting figure from the most recent  
 120 King's Fund Report talking about these [place plated-face?]  
 121 integration between health and social services and that Price  
 122 Waterhouse Coopers estimated how much money can be  
 123 saved, and that it's a huge and, you know, so it's not true that  
 124 cooperation cannot help the current management of crisis, it  
 125 could, but obviously we need things like the long-term  
 126 [inaudible] social services to remain [inaudible – circa 10  
 127 words, speaking very low, something about figures up my  
 128 sleeves] And lastly, but not last, my comment about this  
 129 introduction, just thinking about a time of necessity is also a  
 130 time of potentially creativity, [Will] Hutton recently observing  
 131 that most of our post-war boom came out of creativity [first  
 132 half?] and that the recent drive for efficiency may lay off that  
 133 sort of [self-serving/associate ? [+ something inaudible]]  
 134 working conditions can't continue endlessly.

Critique?

Not sure about  
these numbers,  
check the bill

The language of  
cooperation is not  
focused on  
services. Clear cost  
savings with the  
integration of  
health and social  
care.

Drawing from a  
number of  
arguments and  
examples to view the  
situation as an  
opportunity for  
potential creativity.

135 Zarah Hadid, I rather like, she is a social architect whose work  
 136 I've been looking at for variety and continuity, if you are going  
 137 to redesign the service what would be the design features and  
 138 whose is an interesting design person who is working outside  
 139 the usual sorts of organisational structure, and she talks about  
 140 stepping into these space of productive engagement with  
 141 uncertainty and I think maybe, you know, there is a possibility

Although confusing,  
this speech seems to  
be rescuing a positive  
history of a more  
engaged and creative  
CP. Is this something  
between the positions  
of pro and against  
status quo?

142 that the current disruption in [churn?] we may just stop  
 143 grabbing uncertainties and start [tracking...] some [qualities?]  
 144 [inaudible]. Which means we need to generate a creative space  
 145 and ideally the practices can thrive[sp?]. Again I know that it  
 146 sounds very utopian in the current environment but it's actually  
 147 the message that my own health authority has been quite  
 148 interested in hearing and I think that in this disruption we are  
 149 there is [wriggle?] rooms for something new that could happen  
 150 and I very much excited by all of you who come to get my ideas  
 151 inflamed, allows us to start thinking and talking about what else  
 152 it might happen.

[E] uncertainty and opportunity to be creative. The wider message of opportunity, is what the health authority wants to hear?

153 You got a programme I hope the one or two early arrivals might  
 154 have missed one in which case there is some more on the side.  
 155 What we've got it's a couple of speakers now and our third  
 156 speaker, Jeremy Gauntlett-Gilbert unfortunately had to go to a  
 157 competing meeting which was schedule after he had agreed to  
 158 speak for us, and obviously again there a lots of things that  
 159 happen and he and the DCP decided that the other meeting  
 160 was a priority. But we will be hearing from David Pilgrim, who is  
 161 going to [be this] just [justice] this sense of thinking about  
 162 mental health services and something of a context of the time.  
 163 And then we will hear from Mike Oldridge who will help us  
 164 thinking a little bit about the [inaudible] survey which he has  
 165 contributed to and just give us a sense of where we are now.  
 166 And we will have an opportunity then to hear from the room and  
 167 talk amongst ourselves, there is no doubt that what are our  
 168 ideas and perspectives that everyone here [inaudible, low  
 169 voice]. But let me start by inviting David Pilgrim to talk about  
 170 history [inaudible].

171

172 **[The NHS in historical context: A brief overview – Dr David**  
 173 **Pilgrim, Professor of Mental health Policy, University of**  
 174 **Central Lancashire]**

175

176 David Pilgrim: (~17:10) Just some references if you want to  
 177 know about the history of the health service, first one from  
 178 Charles Webster [inaudible] and the other is more linked to title  
 179 I think is by Clausoffer, [Convictions/contradictions ?] of the  
 180 Welfare State, which is not specific about Britain but it still  
 181 speaks about the problems about the welfare state constant  
 182 crisis and how it deals with that. So if you are interested in this  
 183 [inaudible] that is where you should go. Right!

184 So, a potted history of our service its planning [more?war?] to  
 185 [something] which it isn't, which culturally was important



186 because as everybody knows, or is old enough, it was the sort  
 187 of recollection that attempt to capture in terms of the egalitarian  
 188 spirit around [warfare?] and that persistent view of the social-  
 189 democratic reforms of the Health Service of 1948. Remember it  
 190 was actually a liberal reform and which [inaudible, low voice] it  
 191 was a consensus that came to social-democratic consensus.  
 192 There was great resistance within the profession which we  
 193 know the classic cliché of “stuff the medics mouth with gold”  
 194 before they’re corporate. Interesting mixture therefore  
 195 contingent to the practice of the GPs. It was a false assumption  
 196 in terms of part of how much it would need, [he/it] really  
 197 believes quite naively that a good health service that would  
 198 them reduce the burn on the society and that we would need  
 199 less of it, in fact the reverse has happened. It was soon that  
 200 illness not health would dominated it, so very much reactive to  
 201 [perceptomy??] to [can’t understand] consequent to  
 202 mainstream factors. And it was an early doubt in terms of  
 203 mental illness and mental handicap, so called then, which really  
 204 until the last minute we were not going to be incorporate into  
 205 the health service, we were going to retained as a separate  
 206 system. It was only in the last few months that the planning of  
 207 the NHS actually working.

HISTORY  
 -egalitarian  
 climate  
 -liberal reform  
 -suppose to  
 focus on health  
 become focus on  
 illness

MH + PWLD  
 were not  
 suppose to  
 have been part  
 of the NHS

208

209 So the current policy [status?]is that all parties are obsessed  
 210 about it, it has been a constant policy churn in the health  
 211 services in the health services, perpetually re-structured and,  
 212 which is part of the problem rather than solution most of the  
 213 time. And then, I think, really, in terms of the last 25 years it’s  
 214 been this continuous neoliberal agenda starting with Thatcher  
 215 and actually continued by labour and actually this is one of the  
 216 difficulties about this sort of playground[?] politics in terms of  
 217 alliance with a political party issue is actually that there isn’t,  
 218 wasn’t much difference between new labour and Thatcher did,  
 219 in many ways it went beyond Thatcher ambitions in terms of  
 220 marketisation. At the same time we have this constant  
 221 contradiction of the state wanting to regulate what happens in  
 222 the health service, bureaucratisation and being marketised, and  
 223 there’s a basic tension [inaudible] in trying to be both at the  
 224 same time. And this why you simply to [inaudible] to show that  
 225 competition still here about time, advice, regulation, what  
 226 happen letting to the market [300 euro?]  
 227 And the final question I think is whether the NHS ever became  
 228 a learning organisation, which is one of the new labour  
 229 aspirations when it first came into power in the turn of the  
 230 century. (...)

‘NHS permanently  
 re-structured  
 ’politicians  
 ’obsessed’ about it.

Neoliberalism  
 and  
 marketization,  
 external  
 pressures.

‘Basic tension’:  
 regulation +  
 bureaucratization  
 vs marketization

NHS not a good  
 learning organization

### **APPENDIX III: Initial discursive themes**

- How CP is defined : Doctorate – professional entry level; use of broad range of interventions, assessment, formulation; Creative, unique
- CP positioning in relation to other professionals: Psychiatry: allied but different; Other applied psychologists, Psychotherapists, Counsellours, Community psychologists, etc. Alternative practice? Leadership, governance.
- CP in a privileged place to help with the ‘well-being’ agenda and opportunities to expand activities beyond CBT (In contrast with the repetition that CBT is great.)
- Rhetoric of not enough member engagement not united voice, etc: indications that CP feels small and disempowered; also more evidence to its need to be seen as a hard science, bio-psycho-social model and evidence-base to survive in the ‘market’.
- CP and the threat of the ‘any willing provider’
- CP and the great opportunity outside (but inside?) the NHS
- Mechanization of CP services: commodification of clients and alienation of professionals (The mass production of therapy, the bureaucratization of everyday professional tasks creating distance from the person being treated)
- CP and neoliberalism: how the expert position and market forces sustain each other (also CP as producing and perpetuating capitalist and neoliberal ideology)

**APPENDIX IV: Table of texts used in the analysis with contextual description**

<b>CODE as presented in chapter 3</b>	<b>Reference: author title and date</b>	<b>Contextual description</b>
<b>E19, E21, E10, E13, E23,</b>	Kinderman, Stormont Address: DCP talk at Stormont 9th June 2011	Speech given by the then chair of the DCP whilst at the annual strategy meeting of the DCP in 2011..
<b>E30</b>	BPS, Diagnosis - policy and guidance, 2012	Policy and guidance on the use of diagnosis by CP which had not been withdraw or updated since the statement about the opposition to the use of functional psychiatric diagnosis was published in 2013.
<b>E2, E5, E8, E9, E12, E16, E17, E20, E26, E31, E34, E35, E36, E37, E38, E39, E40, E41, E43</b>	Transcript of Colloquium (Appendix II)	‘The Health and Social Care Bill in a time of necessity’ A colloquium sponsored by the DCP on 6 <sup>th</sup> June 2011 at the BPS London Office, 30 Tabernacle Street, London
<b>E6</b>	(Carr, 2012)	Textbook.
<b>E7, E15,</b>	Division of Clinical Psychology, The Core Purpose and Philosophy of the Profession, 2001	BPS guidelines.

<b>E32</b>	Division of Clinical Psychology, Clinical Psychology: One of the registered practitioner psychology professions, 2010	Information leaflet form DCP about CP to the public.
<b>E14, E4, E18, E22</b>	Committee on Training in Clinical Psychology, Revised standards for Doctoral programmes in Clinical Psychology, 2013	Consultation document.
<b>E24</b>	Kinderman, Chairs Update - May 2011, 2011	Division of clinical psychology website, same version as found in the DCP Clinical Psychology Forum.
<b>E1,</b>	Llewelyn, Beinart, & Kennedy, The key elements of clinical psychology practice, 2008	Textbook.
<b>E3, E11, E28, E42</b>	Pemberton, 2014 New Year message to DCP members, 2014	Personal blog of the DCP Chair 2013-2014
<b>E25</b>	Division of Clinical Psychology, Good practice guidelines on the use of psychological formulation, 2011	BPS guidelines.
<b>E27, E29</b>	Division of Clinical Psychology, Classification of behaviour and experience in relation to functional psychiatric diagnoses: time	DCP Position Statement

	for a paradigm shift, 2013	
<b>E33</b>	NHS, Clinical psychology, 2014	NHS website